Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 0 1 2686

George Allen Tic		r. I-For State Registrar	state of I	Marylar	-	artment o		nd Mer	ntal Hyg		Reg. No.	又ひし	f i	7000
Physicia lical Examir	n/	t. Decedenta Neme (First, Mi		ge Alla	en Tice	, Jr.			2	Month June 12,	uth Day	Aest	2	3. Time of Death 0805 hrs
		4e. Fedility Name (If not Institu 116 5th Street	ition, give stre	et and num	ber)		4b. Cily, Town, Lothian	or Location	of Death			County of		
Funeral Director		5. Social Security Number	8, \$ех	7		last birthday)	If Under 1 Y	ear If Und		1) [areign	place (State or
Director	ŀ	579 96 0658 Usuel Rasidance of Dacadeni	MXX.	2 F	45	Yra		dyb Tiodi	V I IVIII.	Dec 4;	1965		Cour	nuy) Wash DC
* as *	1	10a. Stete 10b. Cour	•		10c. Cit	y, Town or Local	jón							10d. Inside City Limits
Maryland 28a-f show talks: 3.	Director	Maryland Anne 10e. Street and Number	Arundel			Lothian	10f. Zip Code				ina Citi	zen of Whe		1 Yes 2 X No
the Market		116 5th Stree	t					711			_	United		`
the wife	Funera	11. Marital Stetus 1 X Never Married 2	Married 12.	Was Deca Armed For	dent Ever in cas?		s Docedent of	Hispanic Or can, Moxica	igin? (Spe n, Puerto R	cify Yes or N	ė=	14. Reca - White,		an Indjan, Black,
fler der	by Fu		Divorced If Ye	Yes s, Give Year letos:	2 X No	1_	_			•	ŀ	Specify: 1	with it is	2
Fours 2		15. Decedent's Education (\$ Elementary/Secondary (0-)	pacify onty hi	ghest grade Coll ege (1-			out of working				16b. i	Kind of Busi		
Milin 73	Completed	10th		conede (1-	4 Of 3+3	Carr	enter				Ca	onstruc	tion	
21215-0036 Ald to filed within? Mentl Hygiene. marked elber than cereat, the Media	88	17. Father's Name (First, Mid		· ·				1		First, Middle,		Surname)		
212 Sould be defended	10	George Al 19a. Informent's Name/Reletio	nship (Type,	Print)		19b. Meilln	Address (St	reat end Nu	MOSETTE mber or Ru	<u>iry Joho</u> rai Route Nu	ulski Imber, C	Ity or Town,	Stato,	Zip Code)
h, MD tead 2 stor tead 2 stor tree 2 stor		Rosemary Tice (20e. Method of Disposition			200	. Place of Dispos	h Street	, Lothi		20711 Date	200	Location - C	ity or "C	nun State
Baltimore, MD 21215-0036 pemit. Pages 1 sada Sadalte Sidel within 72 fears after death with the Maryland Department of Health and Menul Hygiene. Important If from 27 fr married eller than "tainmal", or those 224 or 284-6 fre injury or other transmitteerest, he Medical Essentian cont. he restrike a fears		1 Burial 2 Crema 4 Donation 5 Other		temoval from	m Stoto	crematory or at Lee Cremat	nor plece)							Wil, Side
Safti emit. 1 Sepertim imports ellery o		21 dignature of Funerel Serv	ice Lisensee	_ 1	20155	22.1	lame and Addr		ty Lee		Home	e,Inc 6	633	Old Alexandri
Physician		20 Part I. Enter the disease	or complication	ons that car	Jaed the dear	ih. Do not enter t	erry Road	, Clint	cardiec or i	20735 respiratory as	rest, she	ock, or hear		Approximate Interval
/Medical examiner		failura. List only one can immediate Cause (Final disco or condition resulting in death	50 a.Que	tiapi	ine In	toxicati	.on							Between Onset and Death
	5	Sequentially list conditions, if any, leading to immediate	b. Due	lo (oras a q	onsoquanca	of):	•							
	Examiner	cause. Enter Underlying Cau (Disease or injury that initiate events resulting in death) Ly	d G.	to (or as a d	:Onsequence	o():								
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66, ate be c Apriore	u'Medical	I UNPENDED	1 23		Ja , Z / ,	28a-f,p	er me,g	10 0-	29-11	l sm	23	d. Date of d	allvery	
40 40 E E	Physician	23b. Was decedent prognant i pest 12 months? 1 Yes 2 No 9		Live bir	th nt at time of c	2 Fa	tel deeth :	3 Ectop	ic pregnan	cy		Month	De	ay Yoar
, P.O. Box 6 ires that the death on signed by the artenti to detached for use		Part II. Other significant con	1			resulting in the I	anderlying caus	e given in P	ort I.	23e. Did	tobucco	usa contrib	ute to th	ne cause of death?
of Vital Records, P.O. og Physician: The law regaines charte the factorian that have signed by ment directly, page 2 should be desired.	ted by					***								ibly 4 🗹 Unknown
ital Records kins: The law regal restificate has best	Completed	******						W		24e. Wes	psy om <u>ed</u> ?	pri de	or to co uth?	opsy findings avellable impletion of cause of
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Fryk Fryk	To B	1 Yas 2 No 27. Manner of Death	Hospi	۱۱۰۰ استا	putiont 2	ER/Outpetient		Other ₄		Home 5				Scene
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Division na or Attendi na after death. Na Director / led in by the fu	rtific	3 Suicido 8 🕱 C	ould not be	28a. Place	of injury - At	home, farm, stre		e building, e	etc. 2	ef. Location or Town, Lothia	(Street a State)	and Number	or Run	Route Number, City
Division of 'To the Boatin or Attending Pa within 24 bears alser death. To the Boarsh Director Afterl completely filled in by the funest		29a. Certifier : Certifying	Physician:	(Specify) I'o the best	Resid	idge, deeth occu	red at the time,	date and p	ece, end d	Lie to the cau	ise(s) ar	ad manner a	s state	d.
To the To the comple	Medical	29b. Signature and title of cer	nd renimaxi and	the basis of manner sta	examination	and/or investiga	tion, in my opini	en, death o	ccurred at	the time, date	and pla	ace, and du	to the	causo(s)
	-	7//	11 1	11-01	77	λ		inse numbol C.M.E.	OCME	<u>.</u>		ie 13, 20		th, Day, Yeer)
		30. Neme and address of per Theodore M. King,	ion who comp Ir., MD	leted dause	of death (its	m 23a) Examiner	900 W Ball	imara Ca	reel Da	Itimere 14	J 242			
		31. Date filed (Month), Day, Ye			Nedical	ture .		miole 2	,eet, ba	umore, M	L 212	.Z3		
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			State of Maryland / Department of Health and Mental Hyg		
		1	1 - State of Waryland / Department of Health and Wental Hyg		0002
-			Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Dogs 2. Date of Dogs		Time of Death
	Physicia: Medic			Day Year	:50 P.M
	Examin		4e. Facility Name (If not institution, give street and number) 4b. City, Tewn, or Location of Death	4c. County of Death	
			5610 Avonshire Place, Unit D Frederick	Frederick	
	Funeral Director	ľ	5. Social Security Number 6. Sex 1 7. Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birth Age (in yrs. lest birthday) If Under 1 Year If Inder 24 Hrs. 8, Date of Birthday If Under 1 Year If Inder 24 Hrs. 8, Date of Birthday Inder 24 Hrs. 8, Date of Birthday If Under 1 Year If Inder 24 Hrs. 8, Date of Birthday If Under 1 Year If Inder 24 Hrs. 8, Date of Birthday I	9. Birthplace (Country)	State or Foroign
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- Féan	883	ā	MD Frederick Frederick		☐ Yes 2 X No
4	Za or	Funeral Director	106. Street and Number 10f. Zip Code	10g. Citizen of What Country?	
4	ems 2	E I	5610 Avonshire Place, Unit D 21703	United States	
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35	ural', IExa	ted	1 Nover Morried 2 Murried 1 Yes 2 No Specify:	Specify: White	
Baltimore, Maryland 21212-0036	spoil of the Mark Mark of the cease was the marker as a second of the marker of the Ma	Completed	15. Decedent's Education 18a. Decedent's Usual Occupation (Glive kind of work done during most of working	16b. Kind of Business Industry	,
112	r than the r	ပ်	Elementary/Secondary (0-12) College (1-4 or 5+) // (Cashier	Auto Sale	
ğ	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Be	17. Fisther's Name (First, Middle, Last) 18. Mether's Name (First, Middle, Last)		:5
Jac	Wents Ments arked affice	욘	Frank Shallenberger Mary Ethel B	oerstler	
ชื่	l sime		19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number	; City or Town, State, Zip Cedo)	
2 ; 0 :	ems 2 Hearth em 23 Bher to		Cheryl Preston / daughter 6228 Rainier Drive, Frederick		
٦ آ	10 H		1 XBurlel 2 Cremation 3 Romeval from State Cemetary, Crematory or other place)	20c. Location - City or Town, S	
<u>=</u> ;	ertan ertan ertan injuri		4 □ Donation 5 □ Other (Specify) Norbeck Mem. Park 06/20/2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & B	Olney, Maryla	ind
ä	permit. Page 1 and 2 Should be 1 Department of Heeth and Menta Important if item 27 is marked any injury or other traumatic e- once.		► Carpelie 1021 M01222 106 E. Church St., Frederi	ck. MD 21701	. nome
			23a. Part 1. Enter the discoso, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or reepiratory amendad, or heart failure. List only one ceuse on each line.	ost, Apr	roximate
P	hysician/		Immediate Cause (Final disease or condition disease or condition destrib) Heart disease or condition at Heart disease / coronary artery disease	Cor	rvai Between et and Death
	Medical Examiner		Due to (or as a consequence of):	SEE	
		i	Sequentially list conditions, b. Stroke		
]	g ž	Medical Examiner	Sequentially list conditione, if any, leading to immediate course. Enter Underlying Course (Discose or linjury that inhibited events.		
	ri and	EX	that initiated ovents resulting in death) Last Due to (or as a consequence ot):	-	
္က	vicase de execisios rig physician end s es the burial-bans?	ical	d		
9780					-
9 X	ath oen attendir for use	ian	23b. Was decedent pregnant 23b. Was decedent pregnant 23b. If yos, eutcome of pregnancy 1	23d. Date of delivory	and the same of th
Box	of the g	ıysiç	1 Yes 2 X Ne 4 Pregnant et time of douth 5 Other (specify) 9 Unknown 9 Unknown	Month Day	Year
Division of Vital Records, P.O.	that in ine of by a declar	Completed by Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. Did to	phacco use contribute to the ca	use of death?
ds,	en sig en sig en sig	led t	emphysema, high blood pressure	Yes 2 No 3 Probably	4 □ Unknown
Š	\$ 28 C 2 S D 3 S D	ple	246. Was		
æ	The Take h	15	CO utubo perie	rmod? death?	
<u>इ</u>	pertificing sector.	Be	b) 25, Was case referred to medical examiner? 28. Place of Death (Check arily one)	- A	
>	Phys reldt	2	1 Inpotiont 2 I ER/Outpatient 3 DOA Outs 4 Nursing Home 5 M Reeld		
E :	adh. Ata e fuis	Certificate:	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe h 28d. Descr	ow julinih ocentraq	
isic	r Atte	ertif	3 Suicide 6 Could not be determined determined 28e. Piaco of Injury At heme, form, street, feetory, office 28f. Location (\$	Street and Number of Rural Rou	la Number,
ַ מֿ	To the Hospital or Aftending Physician: The taw requires that the death cell with 124 butters after death. within 24 butters after death. completes filled in by the funeral observe, page 2 should be detached for use completes filled in by the funeral observe.				
	Hosp 24 ho Fune etes fi	Medical	29a. Certifier (Check Check 2) Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the call of the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place and the common opinion.		and meaner stated
	of the Xonta	Σ	only one) 3 Certifying Nurse Prectienor: To the best of my knowledge, death occurred at the time, date and place, and due to the 29b. Signature and little of pertifier 29b. License number	e cauea(s) and manner as alated.	
)			M D TELIZ	29d. Date signed (Month, Day, 6/17/2011	roar)
<i>!</i>	1084		30. Name and address of person who completed cause of death filters 23s) (Type, Petro)		
	U		Larrance DC VII LIC Tlansana Jahanna DC 18 than Circles	erick, MD =	21702
	Sta	te	6 31. Dato flood (Manth. Col. Your) 32. Registrut's Signature		

DHMH 17 Rev 7/2009

nd #5 per FD Co. Health De	6/10/2 pt.] for State Regi
	1. Doord
Physician/ Medical	Jame
Examiner	4a. Facilit

Funeral Director

pernit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mantal Hyllene.
Important if them 27 is marked other than "natural", or items 23a or 23a f show any injury or other traumatic event, the M. Teal Examiner must be notified at outs.

hysician/ Medical Examiner

To the Rospital or Attending Physician: The Jaw requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the tuneral director, page 2 should be defacted for use as the build-transit

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

		Type or Print in							
æp	For	State of Maryla	nd / Depa	artment of H	ealth and M	lental Hyg	iene	1100	20003
1	State Registrar		Cer	tificate of D	eath	F	leg. No	2011	20003
1	Docedent's Name (First, Middle, Last)				2. Date of Dea		Value	3. Time of Death
	James Cutler Vicke	ery, Jr.			¥	June	04	2011	21:18 M
4	a. Facility Name (if not institution, givo	stroot and number)		4b. City, Town, or	Location of Douth		4¢.	County of Deet	h
1	Anne Arundel Medic	al Center		Annapoli			A:	nne Arui	
δ.	Social Security Number 6, Se	X OM2□F 7.Ago(In yra	. last birthday)	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Yearl	9. Birl Cor	thplace (State or Foreign
Ľ)32-24-5259 13 022:34-5259 Sual Residence of Docodent	77	Yrs.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	08/09/1	933	New	York
	Da. Stete 10b. County	100.0	City, 'l'own or Lo	cation					10d. Inside City Limits
- 1	Maryland Anne Art		nnapoli						1 🗆 Yoz 2 🗘 No
≝ L	0e. Street and Number			10!. Zip Code			10a Cl	tizen of What Co	
a l'	846 Woodmont Road			21401			_	ited St	-
51,	1. Marital Stutus	12. Was Decedent Ever In	U.S. 13.		counte Ortoln? (So.	activ Yos or No-	1	14. Rupo - Arne	
<u>,</u>	1 Novor Married 2) Married	Armed Forces? 1 □ XYes 2 □ No If Yes, Givo	101	Was Docudent of His If Yee, specify Cubar	, Moxican, Puerto	Ricen, etc.)	1	Bluck, Whit	e, etc.
	3 Wildowood 4 Divorced	If Yes, Givo	1-59	1 ☐ Yoo 2 ☐XNo	Specify:			Specify: Whi	te
Completed by F	15. Decedent's E	ducation	16a, Dece	dent's Usual Occup	atlon		16b. K	and of Business	Industry
ᇎ	(Specify only highest gra Elementary/Seconday (0-12)	College (1-4 or 5+)	ille. L	kind of work done d OO NOT use retired)	uring most of work	ang			
<u>ة</u> إ		4	Sales	Manager			Tei	evision	Station
m 1	7. Fether's Namo (First, Middle, Last)				18. Mother's Nur	(First, Middle,	Maiden V	Surname)	
<u> </u>	James C. Vickery				Jeannie	Sontag	A TC	Ket y	
- 1	19e. Interment's Name/Relationship (?)	ypo, Print)		Ing Address (Street 4					
	Anne Vickery/Wife			Voodmont R	load, Ann	apolis,	-		
12	20e. Method of Disposition 1 ☐ Burtal 2 ☐ Cremation 3 ☐		 Place of Disp cometery, cre 	osition (Name of matory or other place	o)	Dato	20a. L	.ocation - City o	Town, State
L	Other (Spech	w IKa	alas Cre	ematory	06/0	6/2011	Edg	ewater,	Maryland
Γ	21. Signafaya piya inarai service Licano	946		2. Name and Addres					
_	1110/1/	- W. W						lgewater	, MD 21037
	23a. Part 1. Enter the disease, or com shock, or heart fallure. List only of	plications that caused the d one cause on each line.	eath. Do not er	ter the mode of dyln	g, such as cardiac	or respiratory er	rest,		Approximate Interval Between
	immediate Cause (Final disease or condition	a. Due to (or as a cone	Can	v Ade	norwo	hum a			Onset and Death
	resulting in death)	Due to (or as a cons	equence of):						
<u></u>	Sequentially list conditions,	b							4 days
틭	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying	Duo to (or us a cons	equence of):						
ğ	Cause (Disease or linjury thut initiated events resulting in death) Last	C. Duo to (or as a cons	sequence of);	The second secon					
夏									
ledical Examiner		d							
፮	IF FEMALE: 23b. Was decedent pregnant	23c. If yee, outcome of gre		_				23d. Date of d	بحضالات عد
<u>G</u>	in the past 12 months?	t □ Live Birth 2 □ 4 □ Pregnant at time		☐ Ectopio pregnant ☐ Other (specify) _	-			Month	Day Year
bys.	0 Unknown	9 Unknown					1		
<u>ج</u> ا	Part II. Other significant conditions of	contributing to death but no	t resulting in the	underlying cause gl	von in Part I.	23o, Did (chacco	use contribute	to the cause of death?
凉	Mills and the second se					1 🖼	100	2 □ No 3 □	Probably 4 🗆 Unknown
흦						24a. Was		24b. Wore a	utopey findings available
E							ormod?	death?	
Q P	25. Was case referred to medical	1		26. P	lace of Death (Che	1 Tes	2 - 1	NO 1 LUT	ea 2 □ No
2	examiner?	Hospitel:	2 ☐ ER/Outpat	lont 3 DOA OII	er:	Home 5 T Ros	ldence	6 Other (Spe	acity)
į	27. Manner of Doubh	28a Deta of Injury (Month, Day, Yea	28b. Time	of 28c. Injur	ry at	28d. Describe			
<u>3</u>	1 Natural 6 Ponding 2 Apoldont Investigation	on .	, ,,,,,,,		Yor 2 □ No				
E.	3 Sulcida 6 Could not 4 Homioide dotermines		At horne, farm, (ec//v)	straet, factory, office	, , , , ,	28f. Location City of To	Street a	and Number or F	iurai Routo Number,
alC							100		
Medical Certificate: To Be Completed by Physician/M	(Chock 2 - Modical Exar	yelclan: To the best of my k ninon: On the back of exemi	ation and/or inv	estigation, in my opin	lon, death occurred	at the time, date	und plan	co, and due to th	a cause(s) and manner stated
Ž	only one) 3 Cortifying Nu 29b, Signature and title of certifler	reo Practioner: To the best	of my knowledg	e, death occurred at if	ne time, date and p	lace, end due to t	he caus	o(s) and manner of Date signed (Mod	as stated.
	D / a	-					200.1	Line 1 1.	INV, WILLY, TOUT)
	30. Neme and address of person who	Jack D. O	flam against		フロイをエ		0	17/11	
				a remai	Pulle	A		, ,	
	I Mr. JL	المال سلام مسكور م	(1) PY 1 -	M - 1	(), <u> </u>				1000
e	31. Dato filod (Month, Day Your) JUN 0 7 20	S Registrar's S			1-1-W	ay 11	<u>`</u> \\	rapul	smo.

State Registrar

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		State Registrar Decedent's Name (First, Middle, Lat		Cer	tificate of D	2.1	Reg. I		3. Timo of Death
Physiciar Medica Examine	al .	BERNARD In. Escility Name (if not institution, give	WADE		4b. City, Yewn, or			Dey Year 26 2011	Q:18PM
3		GENESIS CR.	ESCENT CITIE			IVER DAL	C Date of Birth	lo, County of Deat	
Funeral Director		22L-2L-4419 Jausi Rosidence of Decedent	ex 7. Age (In yrs. I	Yrs.	Menths Days	Hours Min.	Month, Day, Year NOnth, Day, Year) Co	hplaco (State or Foreign untry) DC
aryland a-f show Hed at	-	MD Prince (y, Town or Lo inton	cation				10d. Incide City Limita
with the M 23s or 28 st be not		10c. Street and Number 7508 Silver Fox			10f. Zip Code 2073	5	10g.	Citizan of What Co	AZU (Yuniry?
permit. Page and 2 should be fized whitin 72 hours after death with the Maryland Department of Health and Mental Hygiene. Insportant of Health and Mental Hygiene. Insportant is frem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other transmatic event, the Medical Examiner must be notified at once.	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Wildowed 4 ☐ Divorced	12. Was Docodent Ever in U. Armed Ferces? 1 ☐ Yes 2 ☒ No If Yes, Give Your or Dates.	- 1	Was Docodent of Hi If Yee, specify Cuba 1 🏻 Yee 2 🖔 No	spanic Origin? (Specity n, Mexicun, Puerto Fice Specity:	Yes or Ne- n, etc.)	14. Ruee - Ame Black, White Specify: B]	a, etc.
72 hour n *oatu <u>fed</u> scal	nplet	15. Decedent'r E (Specify only highest gi	ade completed)	16a. Dece (G/ve	dent's Usual Occupi kind of work done o	ellon luring mast of working	165	. Kind of Business	Industry
within yalene.	Be Co	Elementary/Secondey (D-12)	College (1-4 or 5+)		senger			arrier S	ervice
'd te fle. Mental H arked of	To B	17. Father'e Neme (First, Middlo, Lazt) Otîs Wade	9			18. Mother's Name (File		en Surname)	A 484.000 144
d 2 shou alth end 1.27 is m ar trancm		18e. Informant's Name/Reletionship (Michael B. Wade				and Number or Rural Re at Rd. apt21			
hage I an ent of He no Hitem ry or othe		29e. Method of Dispesition 1 ⅓ Burtal 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Spec	Removal from State	Place of Disponentery, cro	ocition (Name of matory or other plac	Dute	200	Location - City on	Town, State
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rrequires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-Varius)	Completed by Physician/Me	IF FEMALE: 23b. Was decedent prognant in the past 12 months? 1 □ Yes 2 □ No 8 □ Unknown	23c. If yes, outcome of program 1 Live Birth 2 Fe 4 Pregnant at time of	tal death 3	Ci Ectopic pregnanc	су		23d. Date of do Month	illyery Day Year
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To the Hospital or Attanding Physioiam: The faw requiree within 24 hours after death. To the Funeral Director: After this certificate has been signompleted filed in by the funeral director, page 2 schould be	Medical Certificate: To	27. Manner of Death 1 Netural 5 Pending 2 Acoldent Investigation	1 1	28b. Time o Injury	of 28c. injur	4 A Nursing Home	5 🗀 Rosidoneo 11 wed edinocoO .		=(<u>6/)</u>
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₽. <u>₹</u> ₽.8		29b. Signeture and fittight certities	War.D		290, Licens	64208	29d,	5./27/	(), Dey, Your)
23		30. Name and address of person who Soudia HUSE	completed esuse of death (Ite Len 4409	т 23а) (Турв. Еал	Print) thest	64208° Hwy,	Rinera	tale m	10 20737
Sta Registr		31. Date flied (Menth, Day, Year)	32, říogistrar's Sign	ature	1				

DHMH 17 Rev 7/2009

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	1	For State	ate of Maryland	/ Departme		and Me	ental Hygi			20005	
Physicia		Registrar . Decedent's Neme (First, Middle, Last)	160		<u> </u>		2. Date of Donth		2ď¶1	3, Time of Death	
Medic	al L	FRANCES	E.		WARD		JUNE			1:40 P M	
Examin	er. ⁴	e. Facility Name (it not Institution, give street a		1	y, Town, or Location			4c. Co	unty of Death	10.00	
<u> </u>		FOREST HILL HEALTH Social Security Number 6. Sex	7 Ago (In yes Inn		FOREST		8. Date of Birth		HARFO	KL) place (State or Foreign	
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Fran Tr	E	Elementary/Seconday (0-12)	ollege (1-4 or 5+)		work done during mo uso retired)		_	Δ Ι	. 40	•	
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semit. Page 1 and Department of Hea Important: If fern any injury or othe once.		1 🖾 Burial 2 🔲 Cromation 3 🖂 Rema		lace of Disposition (emelory, crematory		Jun	e 1/,				
ift Pa strame stram injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Scrytte Liounside	Dee	r Creek	and Address of Fac					11, MD.	
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ehysician/ Medical Examine		23a. Part 1. Enter the diaease, or complicate shock, or heart feliure. List only one car immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to for os o conseque	ا المحمد (الم		as ourdiac o	r respiratory arm	est,		Approximate Interval Botwoon Onset and Death	
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UNISION OF VITAL RECOLUS, F.O. the or Attending Physician: The law requires that the safer death. In other for Affer this certificate has been signed by the law the funeral director, page 2 should be detach.	Comp	sutopey prior performed? dest 1 □ yes 2 1 □ No. 1 □									
	8	25. Was case referred to medical examiner? 4. Diver a Si No. Diver Diver									
Physic Helson	2	1 100 5 1100	1 L inpotiont 2 L			-Nursing Ho	omo 5 🗆 Resid			(fy)	
arching t	cate	1 Natural 5 Pending	28a. Dato of Injury (Month, Day, Year)	23b. Time of Injury M	28c. Injury at work? 1 🔲 Yes 2	5 □ No .	28d. Deacribe h	ow lujury o	poourred		
ital or Atta ins after de ral Directo	al Certif	3 Bulcide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif)	ome, farm, stroot, fa V)	atory, office		28t. Location (S City or You	itreat and in, State)	Number or Ru	ral Route Number,	
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To with the	1	29b. Signature and title of certifier		,	29c. Lloense numb				signed (Monti		
1	1	Down 500	~		D32285			Jp	14,26	211	
10 de	1	30. Name and address of person who comp	eleted cause of death (item		- BEL AIR		21014		- , <u></u>	~/	
		Ad Duty Stud March, Day Visad	1	See a	DEL AIN	La PID.	41014				
Regis	ate Irar	MIN 2 2 2011 Den	32. Hogistrar's Signa	when							

11-04463 **Courtney Angeles**

-04463		Please Type or Print in Black Indelible Ink. Ensure All Copie	es Are Leg	2011	20006
urtney Angel	es	State of Maryland / Department of Health and Mental Hy 1- For State Certificate of Death			
Physici edical Exam		1. Decedent's Name (First, Middle,Last) Courtney Angeles	2. Date of Death Month 14 June 43, 2	Day Year 011	3. Time of Death 0010 hrs
)		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital Baltimore		4c. County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 X 16 16 17. Age (In yrs. last birthday) 17. Age (In yrs. last birthday) 18. Months Days Hours Min.	-1	h(MM/DD/YYYY) 9. Bir	thplace (State or
w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryiand 28a-f show any d at once.	Director	MD N/A Baltimore 10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland boparament of Health and Mental Hygiens "matural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		1203 James Street 21223 11. Marital Status 12. Was Decedent Ever in U.S. 1 News Marital 2 News Merital 3 Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 17) News Merital 3 News Puerto		United Sta	ican Indian, Black,
after death	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced of Dates: 1 Yes 2 No 1 Yes 2 No specify:	Rican, etc.)		ite
5 72 hours in "natura		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use retired to the property of the control of		16b. Kind of Business/	Industry
21215-0036 unld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	10 Student 17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, M	N/A laiden Surname)	
1215 d be file fental H- narked o	Be	0		Mendell	
MD 2 id 2 shoul lith and M m 27 is m	To	Pamela Mendell-Morales/ Mom 1203 James Street, B		e, MD 21223	
Ore, geslant tof Heal : Hiten		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20-2011	20c. Location - City or	
Baltimore, permit. Pages I are Department of Hes Important: If itel injury or other tr	(21. Signature of Funetal Service Licensee 22. Name and Address of Facility Amb	neral Home,	inc.	
ய உத்தத் Physician		2719 Hammonds Fry 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o			Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			Between Onset and Death
	L	Sequentially list conditions, b		- W	
	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated			11
executed an and al - transit	al Exa	events resulting in death) Last Due to (or as a consequence of): d.			
50, te be exe tysician : burial -	Medic	UNPENDED ☑ AMENDED 2 per me g916 6-24-11 vt IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	
Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1	incy		Day Year
that the or	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	
Division of Vital Records, P.O. In or Attending Physician: The law requires that the rate death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach			24a. Was a	in 24b. Were a	utopsy findings available
Recol The law cate has	Completed		autops perfor 1 ✓ Yes 2	med? death?	completion of cause of es 2 No
ician: ician: s certifi rector,	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other4 Nursin			
	: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	•	Residence 6 Other	я.
sion (trending death.	ation	2 Accident Investigation	Pedestrian s	truck by auto	
Division Hospital or Attend 24 hours after death. Funeral Director:	Certification:	3 Suicide 6 Could not be determined CSpecify Local Street 4 Homicide Could not be determined (Specify) Local Street	or Town, St		ural Route Number, City Baltimore, MD
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a		• •	
To with	Med	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	onth, Day, Year)
		Calumth O.C.M.E.		June 14, 2011	
		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore,	MD 21223		
S	ate	31. Data filed (Month, Cay Year) 32. Regist it's Signifure	_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Adam Burt	1- For State Registrar	State of Marylan	-	artment of Health and Mental Hygiene rtificate of Death					
Physician Medical Examine	1. Decedent's Name (First, Market Adam E.	Burt					2. Date of Deat Month June 8, 20	th Day Year	3. Time of Death 0652 hrs
	4a. Facility Name (if not institution Hospital	ution, give street and numb	ber)	4	o. City, Town, or I Elkton	Location of Deat	h	4c. County of Cecil	f Death
Funeral Director	5. Social Security Number 128 – 74 – 0251	1 M 2 F	Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24Hr		th(MM/DD/YYYY) 74	9. Birthplace (State or Foreign NY Country)
the Maryland a or 28s-f show any tifled at once. Director	Usual Residence of Deceden 10a. State MD 10b. Cour MD 10e. Street and Number 88 Elktor	Cecil	10c. City, Tow	vn or Locatio		kton 219		0g. Citizen of Wha	10d. Inside City Limits 1 1 Yes 2 No at Country? USA
s after death with rath, or items 23 niner must be no by Funeral	11. Marital Status 1 X Never Married 2 3 Widowed 4	1 Yes Divorced If Yes, Give Year or Dates:	es? 2 X No	If Ye	Decedent of Hisps, specify Cuban, Yes 2 No	panic Origin? (S Mexican, Puerto specify:	pecify Yes or No- Rican, etc.)	- 14. Race White, Specify:	American Indian, Black, etc. White
21215-0036 uld be filed within 72 hour Mental Hygiene, marked other than "natue event, the Medical Exam To Be Completed	Elementary/Secondary (0-12 17. Father's Name (First, Mid	College (1-4-0)	or 5+)	during mo	st of working life. Employe	po NoT use ret	^{ired)} tist	Maiden Sumame)	Art
MD 2121 (d 2 should be fill the and Mental H nn 27 is marked numatic event, f	ROY Grego	-	ather	9b, Mailing <i>i</i>	Address (Street	Susan and Number or	Rural Route Num	erville	, State, Zip Code) 11964 Island NY
MOCE Pages 1 ent of H unt: If i	20a. Method of Disposition	tion 3 Removal from	20b. Place	of Dispositi	North on (Name of cem r place) remator	etery,	Date / 14/11		City or Town, State
Balti permit. Departin Importi	21. Gignature of Funeral Serv	Victo		22. Na 5 0	me and Address arles I T E. Fo	of Facility Srt Ave	Zens Fu	neral 1	HADe 27230
Physician /Medical Examiner	23a. Part I. Enter the disease, failure. List only one cau Immediate Cause (Final disea or condition resulting in death	use on each line. ase a Seizure	disorder	not enter the	mode of dying, s	uch as cardiac o	or respiratory arre	est, shock, or hear	Approximate Interval Between Onset and Death
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0, be executed sician and burial - transit		AMENDED It 23a, pt. I	em# 19b, I,27,28a	per f	h,g916 6 r me,g910	-23-11 6 6-30-1	sm ll sm		
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 t	23c. If yes, out 1 Live birth 4 Pregnant Unknown 9 Unknown	come of pregnancy at time of death	y 2 Feta 5 Othe	death 3 [Ectopic pregna		23d. Date of d Month	lelivery Day Year
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Division of Vital Records, P.O. tai or Attending Physician: The law requires that the rs after death. at Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P							24a. Was a autops perform	sy pri m <u>ed</u> ? de	ere autopsy findings available for to completion of cause of eath? Yes 2 No
F Vital Physician: r this certifical director, To Be (25. Was case referred to med examiner?	Henrital:	atient 2 ER/0	Outpatient		of Death (Check	only one) ng Home 5 🗌 F	Residence 6	Other:
ion of trending Ph death. ttor: After t y the funeral		28a. Date of International Month, Day and Month, Month, Day and Month, M	y,Year)	Time of Inju	ıry 26c. İnjury	at Work?		ow injury occurred	d
Division of To the Hospital or Attending Physical 24 hours after death. To the Funeral Director: After completely filled in by the funeral edical Certification: Tedion 1		ould not be etermined (Specify) B.	fInjury - At home, f athtub a	t resi	ldence		Elkton,	ate)88 E1k Md.	or Rural Route Number, City side Rd.
To the Ho within 24 To the Fu completel	(Check only 1 Certifying one) 2 Medical E	Physician: To the best of xaminer: On the basis of ex and manner state	xamination and/or						
P S	29b. Signature and title of cert	ifier			29c. License O.C.M			29d. Date signed June 9, 201	1 (Month, Day,Year) 1
8	30. Name and address of pers Ling Li, MD Assis	on who completed cause of tant Medical Examin	,		Street, Baltin	nore, MD 21	223		
State Registrar		32. Fegist	re's Signature	har					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 55AM 20 Year Medical 4a. Eacility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death DENESIS KANDAUS ALTIMORE KANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) AV 26,1935 1 D M 2 AF Hours Min. North Carolina 245-38-9581 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🖺 No Randallstown Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 U.S.A. 9109 Liberty Road 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Janitorial Custodian 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel Riley Bessie Azalee Choates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 714 Henry Avenue, Gastonia, North Carolina 28052 1 and 2 s of Health item 27 Mary E. Brice 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gaston County, permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Trinity Amazon 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-25-11 4 ☐ Donation 5 ☐ Other (Specify) North Carolina Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michan 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) OCARDIAL Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Pregnant at time of death been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has performed 1 Yes 2 No Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to-medical Be 26. Place of Death (Check only one) examiner? Hospital 24 No 1 Yes Other: ည 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6095 MARSHALLE DR. EUCRINGE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 24 p M Medical 4a. Facility Name (if not institution, give street and number, or Location of Deat **Examiner** 4c. County of Death Harbor Baltimore If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Min March 23, ^{Year}1944 Maryland Director 214-42-780 67 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Anne Arundel Pasadena 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be once. 21122 Funeral USA 865 Deering Rd. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) law enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Barbara Jean Fried Harry Timmons Bunting 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2692 Valiant Knight Dr; Finksburg, MD 21048 Eric A. Burns - stepson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place 21. Signatur Co Euneral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No sate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? perform Yes 2 No 1 ☐ Yes 2 ☒No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Hospital Other: 2 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1. Natural 5 Pending 4 hours after death. uneral Director: Afted filled in by the fur 1 Tes Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 0 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) RESOUD

Registrar

State

Varover Street Baltimore

who completed cause of death (Item 23a) (Type, Print)

3001 South

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2<u>011</u> Physician/ Month Coleman Louise Hedley Effie 16 10:20 AM Medical June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Sep. 23, 1924 1 M 2 XF Hours 147-20-9974 86 Virginia Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No VA Halifax Clover 10e. Street and Numbe 10f. Zip Code 9 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 2104 Reverand Coleman Road 24534 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Black r than "natural", the Medical Exal Specify. 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Minister Religion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Sterling Medlev Fannie Ewell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Joseph Coleman, Jr. 9214 Pegasus Ct. Potomac, MD it. Page 1 a. Jepartment of Hr Important; If any injur 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 KBurjal 2 Cremation 3 Removal from State Coleman Family Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 6-23-2011 Clover, Virginia 21. S ty Jeffress Funeral Home e of Funeral Service Licensee 22. Name and Address of Facility 2000 N. Main Street, South Boston, VA 24592 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one cause on each line Immediate Cause (Final Pneumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or imjury that initiated events and resulting in death) Last Due to (or as a consequence of): ng physician a Physician/Medical Box 68760 IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2X No been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Bilateral Contracted Limbs / Cerebrovascular Accident 1 X Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hypertension / Vascular Dementia has page, performed? Yes 24 No this certificate 2 🗌 No 1 Tes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred the Hospital or Attending thin 24 hours after death. 1 XNaturai (Month, Day, Year) injury 5 Pending М 1 Tes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ဳ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my knowledge, death accumed at the time, date and place, and due to the o 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) - Smamburda June 16, 2011 D53367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

Rajan Shyamsundar, MD

2 3 2011

31. Date filed (Month, Day, Year)

Effic

oleman,

9801 Georgia AVenue #117 Silver Spring, MD

20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Year Physician/ June 19, 8:13 P Norman Tennison Chapman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3114 Strickland Street Baltimore City N/A Social Security Number 6. Sex 1 🖾 M 2 🗆 F Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) Maryland Months Days Hours Min. Director 218-05-9454 90 1921 Usual Residence of Decedent or 28a-f show 10b. County er than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d, Inside City Limits Director 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3114 Strickland Street 21229 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 X No Specify 3 🗓 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygier is marked other 1 Machinist/Mechanic B&O Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked Philip Chapman Mamie Dash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Bauer-Daughter 8 Wynnewood Ct, Halethorpe Maryland 21227 Department of Health Important: If item 2 any injury or other to once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Loudon Park Cemetery Jun.23,2011 Baltimore Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line, Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician disegne Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has all director, page 2: autopsy 1 Yes 2 No 2 12 No Yes Hospital or Attending Physician; The A hoers after death.

Suneral Director: After this certificated filled in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗆 No Accident Suicide Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) D3/322 86/21/2011

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Registrar

716 MAIDEN CHOICE IN, CATIONSVILLE, Med 2/12g

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

My

32. Registrar's Signature

GARG

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#20b State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's N me (First, Middle, 2. Date of Death Physician/ SAM 201 M Medical **Examiner** 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1 Year 9. Birthplace (State or Foreign Country) Social Security Number If Under If Under 24 Hrs. 8. Date of Birth 7. Age (Ir **Funeral** 216-78-6411 1 M 2 D F Months Days Hours Min. 7 Month Pay, 19158 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MDYes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 608 00145 ane 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industr (Specify only highest grade completed) Give kind of work done during most of working ife. DO NOT use retired) fdav (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle Name (First, Mide မ nformant's Name/Relation ral Route Number Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 6-28-2011 Baltimore, MD 4 Donation 5 Other (Specify) New Cathedral Cem. 21. Si x at re of Funeral Service Licensee Nat 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) myochrolia IN UNKurun Medical Due to (or de a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Redords, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe death? Performed. 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) 2 No 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 \square No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D47353 JUNE 20, 2011 My) ess of person who completed cause of death (Item 23a) (Type, Print) Buttmore, Carton 400 5-Dir WUR 31. Date filed (Month, Day, 32. Registrar's Signatur State 2 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ 9:12 P.M Shirley M. Cole June Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Owings Mills 7 Byway Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6 Sex 7. Age (In yrs. last birthday, **Funeral** ^{Year}1936 Oct 13 1 □ M 📈 F Min Months Maryland **Director** 220-34-5446 74 Usual Residence of Decedent f show 10d. Inside City Limits it of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes🏋 No Baltimore Owings Mills MD 10g. Citizen of What Country? 10e. Street and Numbe Completed by Funeral U.S.A. 21117 Byway 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes Yes, Give 21215-0036 1 ☐ Yes XX No Specify White 3√Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျှ Mary Jane Markey Harry Benson Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert Lee Cole III / Son 3924 Sunset Dr. Hampstead, MD 21074 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lake View
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or ot XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6/24/11 Sykesville, MD uneral Solvice License 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. Signature 11605 Reisterstown Rd. Owings Mills, MD2111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SMALL Ph, i ian/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 A No Yes 2 No 1 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Other: ပ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: After work? 1XX Natural 5 Pending 1 Tes 2 🗌 No 2 Accident
3 Suicide
4 Homicide 24 hours after death Funeral Director: A Investigation within 24 hours after death

To the Funeral Director:

completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined

Ogn

State

the

Medical

29a. Certifier (Check

only one)

29b. Signature and title

Name and address of p

31. Date filed (Month, Day, Year,

JUN 2 3 2011

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Narang mo

DHMH 17 Rev 7/2009

Registrar

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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artifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

St 340 Owings Mills, mD 21117

29d. Date signed (Month, Day, Year)

fying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

AMEND ITEM#20b, perFH G916 6/29/2011 WS State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 843 AM June Nincken, 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NIA Timore 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 M 2 J Months Min. (Month, Day, Yrs. **Director** Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No to more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic avent than "natural", or þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 110 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Slack Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) α rae nannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) a 100re 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date rematory or other place) 1 Burial 2 Cremation 3 Removal from State King P 624/2011 saltimore, 4 Dopagon 5 Other (Specify) 21. Sig ature of Fune al Service Licer see 22. Name and Address of Facility towell saltimore Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ The consequence of): disease or condition Medical resulting in death) Due to (or **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Usease or impury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2 1 9 Unknown 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Whiknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an performed this certificate 2 🗌 No Yes 2 N 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Doct Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June Minchen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Slear Loch 32. Registrar's Signature 31. Date filed (Month, Day, State JUN 2 3 2011 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

11-04570 Doreen Cox Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

reen Cox		State of Maryland / Department - For State Certificate		i wentai n		2011	20015
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)	Ji Bodiii		2. Date of Deat		3. Time of Death
edical Exami		Doreen Lisa Cox			Month June 18, 2	Day Year 2011	1400 hrs
		4a. Facility Name (if not institution, give street and number)3014 Harview Avenue	4b. City, Town, or Le Baltimore	ocation of Death	1	4c. County of Deat	1
Funeral Director		5. Social Security Number 220-88-9798 6. Sex 7. Age (In yrs. last birthday)	Months Days	If Under 24Hrs Hours Min	_	Forei	thplace (State or gn puntry) Mary land
ь		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ection				10d. Inside City Limits
d 10w any E.		Maryland Baltimor					1 X Yes 2 No
Maryland 28a-f show <u>d at once,</u>	Director	10e. Street and Number	10f. Zip Code		10	0g. Citizen of What Cou	71
the M a or 2		3014 Harview Avenue	21234			U.S.A.	
more, MD 21215-0036 Pages and 2 should be filed within 72 hours after death with the Maryland net of stell and Mental Hygiene. Anti: If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be solified at once.	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	Vas Decedent of Hispa f Yes, specify Cuban, I	anic Origin? (Sp Mexican, Puerto	pecify Yes or No- Rican, etc.)	White, etc.	icen Indian, Black,
s after ral",	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2X No			Specify: Whi	
21215-0036 Montal Hygiene. marked other than "natural", e event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. [16b. Kind of Business/	industry
within piene.	omo	10 HOME	maker	2 bladhada blassa	/Cinch Bairdalin B	Own Home	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If them 27 is marked other than injury or other traumatic event, the Medica	Be C	Melvin James Cox				e Ivantch	
21 thould thould the man is man	J.					nber, City or Town, State	
and 2 sho ealth and tem 27 is traumatic			SRIFEY AV		Date	ore,Marylar	
Baltimore, permit. Pages 1 ar Department of Hee Important: If the injury or other tr		1 Burial 2 X Cremation 3 Removal from State crematory or			01 11		
altin mit. P. portan		4 Donation 5 Other Specify: Ardent C 21. Signature of Funeral Service Licensee 22	Name and Address o	Facility Ma	rzullo	Hanover, Funeral Cha	aryland apel,P.A.
		michael P. marzullo 6	009 Harfor	d Road,	Baltimo	re,Maryland	
Physician /Medical		23a. Part I. Enter the disease, or omplications that caused the death. Do not enter failure. List only one cause on each line.		uch as cardiac o	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
≛xaminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular D Due to (or as a consequence of):	sease				Deau
	_	Sequentially list conditions, b.					
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated					
uted Id ansit	Еха	events resulting in death) Last Due to (or as a consequence of): d.					
50, te be executed nysician and burial - transit	edical	UNPENDED AMENDED					
B760 ificate		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3	Ectopic pregna	incv	23d. Date of deliver	y Day Year
Box 68760, a death certificate be the attending physic ed for use as the bur	Physician/N	past 12 months?	Other (Specify)				
that the de detached f	Phy	Part II. Other algnificant conditions contributing to death but not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ires that the signed by I be detach	d by	Diabetes Mellitus			1 Yes	2 No 3 Pro	pably 4 🗹 Unknown
Vital Records, hysician: The law requirents certificate has been a director, page 2 should	ompleted				24a. Was a autops	sy prior to	topsy findings available completion of cause of
Rec The la	Com				perfor 1 ✓ Yes 2	med? death? 2 No 1 ✓ Yo	es 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatie		of Death (Check of thera		Residence 6 🗸 Othe	Scene
n of V Jing Phy After th funeral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of Month Pow Year)				now injury occurred	
tendi, death. etor: A	atlo	1 V Natural 5 Pending 2 Accident Investigation	1 Yes	s 2 No			
Division of Vital Records, P.O. Box 68760, hin 24 hours after death certificate be executed hin 24 hours after death. the Paneral Director: After this certificate has been signed by the attending physician and applietely filled in by the funeral director, page 2 should be detached for use as the burial - transition.	Certification:	3 Suicide 6 Could not be determined (Specify)	eet, factory, office buil	ilding, etc.	28f. Location (S or Town, St	Street and Number or Rutate)	ıral Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurrence on the basis of examination and/or investig					
¥.2 ¥ 8	Me	and manner stated. 29b. Signature and title of certifier	29c. License r			29d. Date signed (Mo	nth, Day, Year)
		(Catalina)	O.C.M.	.E.		June 19, 2011	
/ -		30: Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. E	3altimore Street,	Baltimore, N	MD 21223		
Si Regis	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June 2011 2:39 P^{M} Glenn Lewis Caples Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2380 Dairyland Drive Carroll Westminster 8. Date of Birth (Month, Day, Yea Sept 27, 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 1 X M 2 □ F Min. Hours Maryland **Director** Yrs. Ĩ935 Sept 215-32-6051 Usual Residence of Decedent 28a-f show 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a Funeral 21158 2380 Dairyland Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ⚠ Yes 2 ☐ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filled within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) construction laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Catherine Smith William Clinton Caples 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 193 Fissure Ct; Westminster, Maryland 21158 Josh Ridgely - grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licenses ROTA d S 22. Name and Address of Facility State Anatomy Board Virector Jan S 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine attending physician and I for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the a 9 Unknown P.0. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 XYes 2 No 3 Probably 4 Unknown Completed pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 🗆 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; I **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 X No 1 Yes ု့ဝ 1 Inpatient 2 ROutpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ledical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 X-

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed

31. Date filed (Month, Day, Year)

JUN 2 3

Westminster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2:35 A Medical 4a. Facility Name (if not institution, give street and number **Examiner** Town, or Location of Death County of Death ORKtown BOWIE RIVE PORAP Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex Age (In yrs. last birthday 8. Date of Birth 9. Birthola Countr ce (State or Foreign 1 M 2 F 8920 Days 3 Months Hours Min. (Month, Day, Director Yrs or 28a-f show notified at 10a State death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Bowie 1 X Yes 2 No 10e. Street and Numbe ö 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? 13302 Yorktown Drive 20715 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Force ò þ 1 Never Married 2 Married filed within 72 hours after ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🛛 No "natural" 3 Widowed 4 Divorced Completed Specify: Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Dyzantine Iconographer Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Amos Dukas Julia Vallas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Dukas (Wife) 13302 Yorktown Dr., Bowie, MD 20714 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Pine Grove Cemetery 6/22/2011 Lynn, MA 21. Signature of Funeral Service Licen # e 22. Name and Address of Facility
Solimine-Landergan-Richardson Funeral Home
426 Broadway, Lynn, MA 01904 lun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Physician, Onset and Death Medical resulting in death) Due to (or a a consequence Examiner Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-tran Due to (or as a co resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires cate has been si 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 Yolo Be (25. Was case referred to medica examiner? Division of Vital 26. Place of Death (Check only one) Hospital 1 Tes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) n 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune (Check the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Por 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Lou 31. Date filed (Mont)

M.D.

Lukas,

445 Defense Highway, Annapolis, MD

21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day}2011 Month Mildred June Η. Dowdy 18 8:55 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home -Aged Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign Country) Virginia 6. Sex Funeral 7. Age (In vrs. last birthday) Min. (Month, Day, Yo 1 🗆 M 2 😾 F Hours Director 228-20-8967 85 1925 July 8. Usual Residence of Decedent or 28a-f shov 10a. State 10h County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 9701 Veirs Drive 20850 USA death v 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2X No. Baltimore, Maryland 21215-0036 hours after 1 Yes 2X No Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If tem 27 is marked other than 1 any injury or other traumatic event, the Meagnose. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Navy Relief Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Burns Paul Smith Evelyn Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diana Dru Dowdy - Daughter 114 S. Columbus St., Arlington, VA 22204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Nourial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) Forest Lawn Cemetery 6-22-2011 Norfolk, Virginia . Signature of Fulleral Service License 22. Name and Address of Facility Nollomon-Brown Funeral Home-TD 8464 Tidewater Drive, Norfolk, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or impury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No Yes 2 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: မြ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number (called D0064624 10 En 19,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar SANDEEL

31. Date filed (Month, Day, Year)
JUN 2 3 2011

Walk Dr.

743

Summer

SHARMA

Gatheriba MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jaw Son Month Physician/ narles 1.45 p 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Care uture Baltimor If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year)
Dec 2, 1931 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Georgia 260-52-5832 79 Director Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director MD Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21229 208 Diener Place #101 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 14. Race - American Indian, 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 automotive automotive mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Eva Dye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5817 Chinquapin Pkwy; Baltimore, Maryland 21239 Michele Tolson - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 22. Name and Address of Facility State Anatomy Board Signature of Euneral Service Licensee Ronal d S Wall 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due r as a consequence of): Examiner Securitizely list conditions if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 🖸 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Macam MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LABEM DOLPHINSTR BALTIMOREMD 21217

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUN 2 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Juni James Earl Evans BM Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Normore KROP, MA mound Social Security Numbe **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign M 2 □ F Months Days Min. 245-54-0109 **Director** 72 0472571939 N.Carolina Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4016 Ford Lane 21215 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates Specify: Black 1 ☐ Yes 2 ☐ No Specify: 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 12th Grade College (1-4 or 5+) Mechanic should be filed with and Mental Hygien 7 is marked other the Gold St.Garage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unk Mary B. Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Belinda Davis(daughter) 1132 Newfield Rd., Gwynn Oak, MD 21207 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Park 06/25/11 Baltimore, MD Signature of Funeral Service Licensee Josephadoms of Brown Jr. Funeral Home PA anyi 2140 N. Fulton Ave., Baltimore, MD21217 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart fallure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or s a consequence of): **Examiner** MRING Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): that initiated events resulting in death) Last burialphysician the burial Physician/Medical Box 68760 IF FEMALE use a 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 Yes 2 No jo Pregnant at time of death Day 1 Yes 2 L 9 Unknown been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2-1 No 20 No 1 Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 🗆 Yes 2 No ပ္ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury s after death. work? 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 m DO05113 who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

0/d

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 26 per verb., g916,06/23/2011dhb
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Eugene Ford PM M May 14 8:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Joseph Richey Hospice Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Feb 2 pay, 1 X M 2 🗆 F Months Days Hours Min. 218-86-8543 Director 46 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the M-dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3910 Ridgewood Avenue 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: black Specify: 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) none 12 none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Geraldine White Taylor Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 McMechen Street #402 Baltimore, MD 21217 Geraldine White/mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 💢 Other (Specify) in state Daniel A ಿ tarend Address ರಿಗ್ಯೋ Board 655 W. Baltimore Street °Maylor Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a cons-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ine Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 2 No To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by JB48e Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I autopsy perform 1 Yes 2 No 2 No 1 🗌 Yes Be 25. Was case referred to ivision of Vital 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 Yes 2 No Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Mann Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of ce 29d. Date siggled (Month, Day, Year)

State Registrar 31. Date filed (Mo

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ed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1, 29c per doc g916 6-23-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death (First, Middle, Last) Day 1 **Physician** Simon Frances 04:34AM 201/ /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltmore a N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In vrs. Date of Birth (Month Day, **Funeral** Vear) Months Hours Days 1**X**XM 2□ F 02/12/1934 261-58-3817 Director GREECE Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show ral", or items 23a or 28a-f shov Examiner must be notified at 1 □Yes 2 No Director MIAMI-DADE MIAMI 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 14270 SW 107TH TERRACE 33186 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 21215-0036 1 □ Yes 2 Ϊ No Specify. ģ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER CARPENTRY other Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fill Health and Mental H tem 27 is marked oth ပ ELIEZER **FRANCES** BAROUCH ANN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14270 SW 107TH TERRACE, MIAMI, FL REGINA FRANCES/WIFE 33186 Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages . 1 XBurial 2 ☐ Cremation 3X Removal from State permit. Page Department of Important: If any Injury or once. LAKESIDE MEMORIAL PK 06/22/2011 4 ☐ Donation 5 ☐ Other (Specify) MIAMI, FL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. unu 8900 REISTERSTOWN ROAD, PIKESVILLE, 21208 Approximate Interval Between Onset and Death 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 □Yes 2 □ No Month Day Vear 5 Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to/tleath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a, Was an autopsy performed certificate 1 □Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27, Manner of Peath 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Tune 19, 2011 D-68628 who completed cause of death (Item 23a) (Type, Print) of baltimorn

State Registrar 31. Date filed (Moriti, Vay,

Year

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar	ato of maryia		tificate c	of Death			Re	g. No.		
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Funeral	٦	5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under		der 24Hrs.	8. Date of Birth	n(MM/DD/YYYY		
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		Usual Residence of Decedent										
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ox 687 eath certific	Sa	past 12 months?	LITEIAGDI	irth ant at time of dea	oth	etal death other (S <i>pecif</i> y		oic pregnan	cy	Month	D	ay Year
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Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certificate has bours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	흥	(Check only	Physician: To the besi aminer:On the basis of									
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		9/1/20/1	the Hole	1	20		C.M.E.			June 20, 20	011	
Lard	ŀ	30. Name and address of person	n who completed caus	se of death (Item	23a)							
177		Victor Weedn MD JD				W. Baltimo	re Street, I	Baltimore	e, MD 2122	3		
Sta Registi		31. Date filed (Month, Day, Year	32. Re	gistrar's Signatu	bark	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 7, 2011 10:50 AM Perdita Wright Fortune Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Crescent Cities Center Riverdale Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Octonth, Pay Year 1920 Virginia 90 Director 579-50-1537 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 ☐ No DC Washington 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20011 U.S.A. 5118 North Capital St., NW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: Black 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit, Page 1 and 2 should be filed within 73 Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeper Domestic Work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Betty Coleman Eddie Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington, DC 20011 5118 North Capital St., NW Robert Clifton Fortune (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 6/15/2011 1 X Burial 2 Cremation 3 Removal from State Wright's Family Cemetery 4 Donation 5 Other (Specify) Woodford, VA 21. Sign ure of Funeral Service List nset 22. Name and Address of Facility C.W. Edwards Funeral Home, I P.O. Box 395, Bowling Green, lun 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line DEMENTIA Immediate Cause (Final Physician/ disease or condition resulting in death)) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of performed? ☐ Yes 2 🔀 No perform death? 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Tyes 2 X No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Sprtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature an 29d. Date signed (Month, Day, Year) D0064208

Registrar
DHMH 17 Rev 7/2009

SAADIA

31. Date filed (Month, Day, Year)

EAST

WEST HWY, RIVERDALE MD 20737

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUSAIN

4409

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ 0213 19 vne 2011 DENISE M. FREEMAN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMOre AGNES HOSPITAL N/A SAINT If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🛛 F Days MARYLAND Yrs Director 213-30-2716 78 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director 1 XYes 2 No MD. N/A BALTIMORE 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3401 SPRINGDALE AVE. 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ "natural", or 1 Never Married 2 Married 1 ☐ Yes 2X No filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates BLACK 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmet. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) -12-**HEALTHCARE** -6-NURSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ ARGEE E. FREEMAN ETHEL CORNISH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBBYN M. BLAND (DAUGHTER) 3401 SPRINGDALE AVE. BALTIMORE, MARYLAND 21216 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, ARBUTUS MEMORIAL PARK 6-24-2011 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Saviac Licensee JONATH IN HIBNE R22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Myocasdia NECTION disease or condition *Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate bases. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Let Examine Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific M D47353

State

Registrar

Deni

Reman

900 caton Avenue

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 2 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Amend Ite	State of Maryland m 24a per vei	L Depa Cer	tificate of D	2011 ans N Death	lental Hy	giene Reg. No.	011	20026
ı	Physicia Medic		1. Decedent's Name (First, Middle, Last)	linginia Grego	my			2. Date of Dea Month プレル	Day	Year	3. Time of Death
	Examin		4a. Facility Name (if not institution, give str 533 Beards Hill Road	eet and number)		4b. City, Town, or Aberdeen	Location of Death			unty of Death Tord	1
	Funeral Director		<u> </u>	7. Age (In yrs. las 85	st bi rt hday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl April 1.		g. Birti Staur	pplace (State or Foreign nton, Virginia
	ryland -f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Harford		, Town or Loc	ation					10d. Inside City Limits 1 ☐ Yes 2 No
	ith the Ma 3a or 28a t be notif	ä	10e. Street and Number 533 Beards Hill Road			10f. Zip Code 21001			10g. Citizer	of What Co	
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral		. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X No If Yes, Give Year or Dates.	l If	Vas Decedent of His Yes, specify Cubar ☐ Yes XX☐ No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White ecify: Whi	, etc.
Baltimore, Maryland 21215-0036	rithin 72 hou lene. r than "natu the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)	ation completed)	(Give k	ent's Usual Occupa ind of work done d O NOT use retired) I CT	ation uring most of work	ing	16b. Kind Homemal	of Business I	ndustry
land 2	d be filed w Mental Hygi arked other atic event, I	To Be	17. Father's Name (First, Middle, Last) Otto Moore	1		F	18. Mother's Nam Pearl Unkno	e (First, Middle, M N	Maiden Sun	name)	54
, Mar	nd 2 shoul salth and 1 n 27 is mi er trauma		19a. Informant's Name/Relationship (Type Jon L. Gregory (Son)	Print)	19b. Mailin 533 Bea	g Address <i>(Street a</i> I rds H ill Ro	nd Number or Rura Dad Aberdee	al Route Number	1001 ^{or Tov}	vn, State, Zip	Code)
imore	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1XX Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	ace of Dispos metery, crem rose Ce	sition (Name of latory or other place metery Ju) une 20 2011	Date -		tion - City or Con, Virg	
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Ocensee	olmOQ	²² E	Neme and Address 750 Belair	ì°Füñeral H Road King	lome, P.A. sville, N	Marylan	d 21087	
-	hysician/	77	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.		r the mode of dying		or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a conseque		- / - /					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	Due to (or as a conseque	ence of):						
092	icate be executed physician and s the burial-transit	edical Ex	resulting in death) Last	Due to (or as a conseque	ence of):						
Division of Vital Records, P.O. Box 687	the Hospital or Attending Physician: The law requires that the death certificate be executed that A hous after death. The A brows after death. The Funerial Director, After this certificate has been signed by the attending physician and the Funerial Director, Page 2 should be detached for use as the burial-transity and the funeral director, page 2 should be detached for use as the burial-transity.	Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnan 1	death 3 [Ectopic pregnanc	у		230	d. Date of del Month	ivery Day Year
ds, P.O	quires that the series of signed by and be detailed.	b	Part II. Other significant conditions cont	ibuting to death but not resu	ılting in the u	nderlying cause giv	en in Part I.				the cause of death?
Recor	: The law rec cate has be page 2 sho	Completed						24a. Was auto perfo 1 \(\sum \) Yes	psy	prior to death?	opsy findings available completion of cause of
Vital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	spital: 1	ER/Outpatien	Otho	ace of Death (Checker: 4 Nursing Ho		dence 6 🗆	Other (Speci	ífy)
on of	ending Ph eath. ดา: After th วe funeral	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work' M 1 🗆	at ? Yes 2 🗆 No	28d. Describe h	now injury oc	ccurred	
Divisi	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director. After this certifical completed filled in by the funeral director, and the funeral director.		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location (S City or Tov		umber or Rui	al Route Number,
	ie Hospi n 24 hou e Funer oleted fill	Medical	(Check 2 Medical Examine)	an: To the best of my knowle : On the basis of examination Practioner: To the best of my	and/or invest	igation, in my opinio	n, death occurred a	t the time, date a	and place, an	d due to the	cause(s) and manner stated.
	To the complete of the complet		29b. Signature and title of certifier MSLIGHT MINI	и.0		29c. License				igned (Month	
	(3)		30. Name and address of person who con $\mathcal{A} = \mathcal{A} \mathcal{A} \mathcal{A} \mathcal{A} \mathcal{A} \mathcal{A} \mathcal{A} \mathcal{A}$	pleted cause of death (Item	23a) (Type, P	sint)	N 5-	203	Balt	i mory	MO 21209
E	Sta Registra	te ar	31. Date filed (Month, Day, Year) JUN 2 3 2011	32. Registrar's Signatu	grave france	le!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Erna Gillece June June 22^{pay} 201°1 7:07 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 203 Homewood Road Linthicum Anne Arundel Social Security Number 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) If Under 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth 1 □ M 2 😾 F Year 1921 167-16-1991 Months Hours Min Director 90 Usual Residence of Decedent 28a-f show 10a. State 10b Count Medical Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Linthicum 1 Yes 2 X No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 203 Homewood Road 21090 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No 0. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: "natural", If Yes Give White 3 XWidowed 4 ☐ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Home Maker 12 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked o ပ္ Edward Barling Carrie Faulk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 James Gillece / Son 2905 Guilford Ave., Baltimore, Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. | 06/23/2011 | Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor Aspakinter la 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/) Medical Examiner IVA 1/3 mass Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical requires that the death certificate be Box 68760 as the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

3 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No jo Month detached the 9 Unknown 9 Unknown P.O. signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b page 2 autopsy performed? Yes 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 34 00:59189 6.2 NO Sm

Registrar

State

Jeron

31. Date filed (Month, Day, Year)

23

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BATTOM

5005 Hopkins

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 01331 2011 -RANK LIN 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Mandrin Chesapeake Hospice House Anne Arundel Harwood If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) 6. Sex 1 ☑ M 2 ☐ F **Funeral** Min. Days Months Hours Michigan Director 363-40-3135 69 01/28/1942 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 28a-f show items 23a or 28a-f shring the motified Funeral Director Anne Arundel Harwood MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20776 United States 3675 Solomin Island Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 X No Specify. Completed by Specify: 3 N Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Manager Automotive ath and Mental Hygi
27 Is marked other
r traumatic event, II

17. Father's Name (First, Middle, Last)

4 ☐ Donation 5 ☐ Other (Specify)

Monte Goldman

Be

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

9 Unknown

4 Homicide

29b. Signature and litle of certiffe

Health tem 27 I

permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other or other

Physician

/Medical

Examiner

physician and s the burial-trans

cate has been signed by page 2 should be detacl

funeral director,

death.

Director: filled in by the

within 24 hours a

completely

or Attending Physician; The law requires that the death certificate be executed

Box 68760

P.0.

of Vital Records,

Division

19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Paul Goldman (Brother) 1987 Orchard Lake Rd., Sylvan Lake, MI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State

21. Signature of Funeral Service Lice M01284

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest

shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)

Due to (or as consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of). Due to (or as a consequence of):

IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 24a. Was an

autopsy performed 1 ☐ Yes 2 ☑ No 25. Was case referred to medical

26. Place of Death (Check only one) 6-Domer (Specify) HUSP Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred

Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

29a. Certifier ≠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) d manner stated.

s of person who completed paise of death (Item 23a) (Type, Print) Name and addre m At

31. Date filed (Month, Day,

State Registrar

Bu

DHMH 17 Rev 1/2001

ORIGINAL

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

lever

Vear

1 ☐ Yes 2 TNo

18. Mother's Name (First, Middle, Maiden Surname)

Leona Mandel

48320

20c. Location - City or Town, State

Hebrew Memorial Park 6/10/2011 Clinton TWP., MI 22. Name and Address of Facility Hebrew Memorial Funeral Home

26640 Greenfield Rd., Oak Park, MI 48237

Approximate Interval Between Onset and Death

23d Date of delivery

23e. Did tobacco use contribute to the cause of death?

Month

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Day

pice

House

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 29c. License number

OUS MALIKOI

DEFENSE

11-0460 Rodney	01 Earl Go	ggin	s, Jr. ame	ease Ty	pe or Print i tate of Maryl	n Bla	ck Indeli	ible l i ent of	n k. Ens t Health a	ire Ali (Copies	s Are L	egibi	e.	•	20029
			1- For State Registrar	→ JI	,		Certific					3	Reg. No	See C	1	
	Physici Il Exami			Earl Go	ggins Jr.				_			2. Date of D Month June 19	eath Day , 2011	Year	1.	me of Death 425 hrs
			4a. Facility Name (Liberty Res		on, give street and n	umber)			4b. City, Town, Eldersbu		of Death			c. County of D Baltimore (
	Funeral Director		5. Social Security 1 212-33- 887		6. Sex	7. Age	(In yrs. last birt	thday) 20 Yrs	If Under 1 Y		der 24Hrs.	8. Date of 5–8–1		1/DD/YYYY) 9 Fo	Birthplac oreign Country)	
	any		Usual Residence of 10a. State	f Decedent 10b. County		I1	0c. City, Town	or Locati	ion						10d.	Inside City Limits
		_	MD		timore		•		stown							Yes 2 No
	he Maryla or 28a-f	Director	10e. Street and Nu 4021 Roven	mber					10f. Zip Code	1.33			10g. Cit	tizen of What o	Country?	
	r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status 1 X Never Marri			orces?			s Decedent of es, specify Cul				No-	14. Race - A White, et		ndian, Black,
	after d	P, F	3 Widowed		1 Yes vorced If Yes, Give Yes or Dates:	ar	X No	1	Yes 2 X	No specify	:			Specify: Af	rican-	-American
ٔ و	1 72 hours an "natur cal Exam	Completed t	15. Decedent's Elementary/Second		cify only highest gra	1-4 or 5+)	during m	t's Usual Occu ost of working i	ife. DO NOT				Kind of Busine		ry
215-0036	giene.	E O	17. Father's Name	(First Middle	last)		EMI	rire	fighter		r's Name (First, Middle			<u> </u>	
215	be filed ntal Hy rked of	Be			•						-	Hargra		· ouriamo,		
MD 21	d 2 should th and Me a 27 is ma umatic ev	10	Rodne 19a. Informant's Na Tracey Gog	me/Relations gins/ M	hip (Type, Print)		198	6. Mailing 4021	Address (St Roven R	reet and Nu	mber or Ru	ral Route N	umber, C	ity or Town, S 133	tate, Zip (Code)
Baltimore,	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiewie. In Department of Health and Mental Hygiewie. In partice 17 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dis 1 Durial 2 2 Donation 5	Cremation	n 3 Removal fr	om State	cremate	ory or oth	ition (Name of ner place) al Park	cemetery,	1	Date -2011	- 1	Location - City		, State
3altii	Separtm Mports njury o		21. Signature of Fu	n IS	Licensee				ame and Addr		VV y JL.L				of Ba	alto. Co.
	ysician	1	26a. Part I. Enter th	ne disease, or	complications that of	aused th	e death. Do no		200 Libe						Api	proximate Interval
	dedical aminer	1	failure. List on Immediate Cause (ly one cause	on each line.	•						, ,			Be	tween Onset and Death
-^	anime		or condition resulting	ng in death)	Due to (or as a	conseq	uence of):									
		ě	Sequentially list co if any, leading to in cause. Enter Under	nmediate	Due to (or as a	consequ	uence of):								+	
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760,	reate be physic the bur	/Me	IF FEMALE: 23b. Was decedent	pregnant in th			of pregnancy	_					23	d. Date of deli		
Box 68760,	leath certificate be ex e attending physician for use as the burial	Physician/Medic	past 12 months	?	4 Pregr	iant at tîn	ne of death 5		al death ner (Specify)	BEctopi	c pregnand	су 		Month	Day	Year
P.O. E	to be couptial or Artending Physician; The law requires that the death certificate be extituded by the attending physician 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	百	Part II. Other signi	ficant condit	ions contributing to	death b	out not resulting	j in the u	nderlying caus	e given in P	art I.			use contribute		use of death?
rds,	law requires that has been signed b 2 should be detact	leted							<u> </u>			24a. Wa	is an			findings available etion of cause of
Division of Vital Records, P.O.	ctan: The law certificate has ector, page 2 sl	Completed										1 ✓ Yes	formed?	deat	1?	2 No
/ital	ystcum iis cert directo	Ď,	25. Was case reference examiner? 1 ✓ Yes	rea to medica 2 No	(Hospital:	npatient	2 ER/O	utpatient	_	Other			Reside	ence 6 🗹 O	ther: \$cer	ne
o	After ti	5 i	27. Manner of Deat	h	28a. Date	of Injury	28b. 1	Fime of Ir	`	njury at Work	(? 2 S	8d. Describ	e how inj	ury occurred reservoir		
sion	Attend r death. ector: by the f	catlo	2 Accident	5 Pend	stigation Jun 19,	2011	1419	hrs_		Yes 2 ✓	No				5 15	
Divi	pura or ours after eral Dir filled in	Certification:	3 Suicide 4 Homicide		d not be (Specify)		y - At home, fa	irm, suee	t, ractory, office	e building, e		or Town	State)	and Number of Eldersburgh,		oute Number, City
6	10 the Hospital of Attending Physician; within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	Medical (hysician: To the besing miner: On the basis	of examir										se(s)
• f	3 5 6 8	₹	29b. Signature and	title of certific			2011		29c. Lice	nse number			29d.	Date signed (Month, Da	ay, Year)
			Julio	fal	bryele	1	No		0.0	C.M.E.			Jur	ne 20, 2011		
		ſ	Name and addressVictor Weed		who completed cause Assistant Me		,	900 W	. Baltimore	Street, B	altimore	e, MD 21:	223			
	St Regist		31. Date filed (Mont	h, Day, Year)	32. Re	gistras	Signature	J.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death boodal Physician/ 6:30AM Medical Name (if not institution, give street and number) City, Town, or Location of Death **Examiner** 4c. County of Death Himore (In yrs. last birthday) 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours Min Director show or 28a-f shov notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 Yes 2 ☐ No timore ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify 3 Widowed 4 ☐ Divorced Completed Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Su ည M090M or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City ,ood Method of Disposition 20b. Place of Disposition (Name of ■ Burial 2 ☐ Cremation 3 ☐ Removal from State ings Mills, M Other (Specify) ignature of Funeral Se ws Ser 1. Enter the disease, or complications that caused the death. Do not enter the mode of d 23a. Pag 1. Enter the disease, or complications that caucas shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Chevnis cond Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to minimadiate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) Exami tran and that initiated events resulting in death) Last physician are s the burial-t Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 been signed by the attending should be detached for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ me resoute melanomo Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 2 No Yes 2 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No Other: ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) NO 1010 1 Inpatient 2 ER/Outpatient 3 DOA this No unc. within 24 hours after occu... To the Funeral Director. After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one D S8302 29b. Sign 29d. Date signed (Month, Day, Year) JUNE 22 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST rowson NO CHAMES

State

Registrar

MANON

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6701

M 32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 14^{Day} June June Helen Ginn 2011 9:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Baltimore Stella Maris Towson Social Security Number 6. Sex If Under 1 Year 8. Date of Birth Nov. 9, 1927 If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday Maryland 214-24-6528 1 □ M 2 F 83 **Director** Usual Residence of Decedent 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3619 Dahlia Lane U.S.A. 21220 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. ģ 1 Never Married 2 Married Yes Yes, Give 2 XNo Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: White Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Assembly Line Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lingard Chenoweth Foard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy G. Ginn/ Son Page 1 and 2 3619 Dahlia Lane, Middle River, Maryland Baltimore, 14, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cremation, Inc. 6-17-11 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michae 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) SEPTICEMIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): nding physician and use as the burial-transit Dause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery atter 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Number page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform in 24 hours after death.

The Funeral Director: After this certificate In pleted filled in by the funeral director, page 1 Yes 2 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Ceptifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 15/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TARIQ MAHMOOD, MD TIMONIUM, MD 21093 Date filed (Month, Day

DHMH 17 Rev 7/2009

State Registrar

2011

HELEN GINN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 29d,30 per dr.,g916,06/23/2011dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Da 23 2 2 2 1 Month & Physician/ Cornelia 5 Hinkle mar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Battimore Washington Modical Glen Burnie MD If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** North Carolina 1 □ M 2 🂢 F Months Days Hours Min $\text{an}^{\text{(Month, Day)}}$ 214-30-6717 Director 77 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic average. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Queen Annes Centreville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 127 Deerfield Court 21617 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify: white Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) own home housewife 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Marjory Eleanor Deal Edgar Miller Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 127 Deerfield Court Centreville, MD 21617 19a. Informant's Name/Relationship (Type, Print) Alex Cox/friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) 21. Signature of Funeral Service Sicenses New Director State Anatomy Board 655 W. Baltimore Street Baltimore. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIR Ph_sician/ ATTON PNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and de detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? STROKE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24 hours after death.

Funeral Director: After this certificate has been FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to edical 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: Certificate: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) **S** Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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Registrar DHMH 17 Rev 7/2009

State

within 2

only one

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

TARAK REDOY, MO

Tarak Reddy, M.D., Baltimore Washington Medical Center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

June 3, 2011

29c. License number

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

JOHN HENRY 11-02730 Hagegeorge Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Da April 9, 2011 Medical Examiner 1205 hrs John Henry Hagegeorge 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death S. Hilltop Road in Patapsco Valley State Park Catonsville **Baltimore County** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Hours Months Director 220-68-6893 02/29/1956 countryMaryland 55 1 M 2 F Yrs Usual Residence of Decedent Inv 10a. State 10c. City. Town or Location 10d. Inside City Limits Baltimore Catonsville Maryland 1 Yes 2 No permit. Pages i and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 a v 28s-f she injury or other traumatic event, the Medical Examiner must be notified as anner. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1218 Redcliffe Road 21228 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specity Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes Give Year 77-783 Widowed 4 X Divorced 1X Yes 2 No specify: Unk Specify: White ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Investment Broker Market Research 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Peter Hagegeorge Aurora Fernandez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 736 Heatherstone Loop, Sara Jane Hagegeorge / Ex-Wife Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 06/23/2011 Baltimore, Maryland Metro Crematory Inc. 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee Alyson K 22. Name and Address of Facility Cremation Society of Maryland Taylor 299 Frederick Rd., Baltimore, Maryland 21228 **Physician** Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line en Onset and /Medical Death Immediate Cause (Final disease a. Hypothermia xaminerء or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of) (Discuss or injury that initiated Due to (or as a consequence of): events resulting in death) Last transi Physician/Medical X UNPENDED AMENDED 23a, 27, 28a-f, per me, g917 7-26-11 smsigned by the attending physician i be detached for use as the burial E Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 1 Live birth Day Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✔ No 3 Probably 4 Unknown of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene this 1 Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division found in a cold environment 1 Natural 5 Pending 1 Yes 2 X No fd 12:05 pm in by the fd 4-9-11 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State)S. Hilltop Rd. in Patapsco Valley Park Catonsville, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide found in park (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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State Registrar

29b. Signature and title of certifier

Martes

Margarita Korell MD.

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

and manner stated

Assistant Medical Examiner

32 Regionar's Signature

The Grele

30. Name and address of person who completed cause of death (Item 23a)

April 10, 2011

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per verb., g916,06/23/2011dhb

Certificate of Death

Reg. No For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 201 Tear Physician/ June Leonard Joseph Hersl Sr. 45A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, wn, or Location of Death Middle River 4c. County of Death Examiner Baltimore Cidar Court Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** April 124 Days 216-24-7379 1 🕅 2 🗆 F Months Hours Min 83 1928 Director MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director Middle River Baltimore MD 1 Yes 2 No 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21220 9 Cidar Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ¼ Yes 2 ☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: White 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical ponce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Beth Steel Machinist 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) မ Elizabeth Coleman Charles Hersl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9 Cidar Court Baltimore MD 21220 Margaret Hersl /wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 6/11/11 Baltimore MD Bayview Crematory 4 Donation 5 Other (Specify) 21. Signature of unital Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or compercations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Dementa disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and d be detached for use as the bunal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iirijur that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 \sum Yes 2 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence _6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner; to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D00363

Registrar

State

UMUDA

31. Date filed (Month, Day, Year)

7121

"Security Boulevan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Year Month Physician/ 0730 AM JUNE DOUGLAS HUTCHINSON Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORE of MARYLAND MEDICAL UNIVERSITY Birthplace (State or Foreign Country) Social Security Numberunk 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth unk **Funeral** Days an 5. 1 Hours Min. 1 💢 M 2 🗆 F 58 Jan **Director** Usual Residence of Decedent 10d. Inside City Limits unk 10a. State unk 28a-f shov 10c. City, Town or Location 10b. County death with the Maryland unk other traumatic event, the Medical Examiner must be notified at Director unk 🗆 Yes 2 🗆 No unk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò USA Funeral "natural", or items 23a homeless Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, unk Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc unk 1 Never Married 2 Married ☐ Yes 2 ☐ No Yes, Give þ white Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2X No Specify: Specify 3 Widowed 4 Divorced Completed Year or Dates unk unk 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic
once. (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) unk unk Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, $22\ S$. Greene Street Baltimore, MD 2120119a. Informant's Name/Relationship (Type, Print) University of MD Medical Center 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state ²State and Address of Facility Board 655 W. Baltimore Street Signature of Funeral Service Licensee rector 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or heart failure. List only one cause on each line. Onset and Death

WEEL Immediate Cause (Final Physician/ disease or condition LORAR PNEUMONIA MULTI Medical resulting in death) Due to (or as a consequence of) Examiner OBSTRUCTIVE PULMONARY CHRONIC Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-trar attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 tate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be Hospital 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: work' 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JUNE 20// Ohen R1337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUSAN BALTIMORE OTREMBA 31. Date filed (Month, Day, Year) 32. Registrar's State JUN 2 3 2011

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.															
		State of Maryland / Department of Health and Mental Hygiene												20036	
		Registrar 1. Decedent's Name	e (First, Middle		Certificate of Death					Reg. No. 2. Date of Death				2	
Physicia Medio		Dolores M. Jackson											Year 11	3. Time of Death	
Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death													
Funeral		5. Social Security N	ast birthday)					8. Date of Birth 9. Birthplace (\$				_			
Director		5. Social Security N 148-40-	-8316	6. Sex 7. Aq 1 M 2 X F	63	Yrs.	Months	Days	Hours Min.	(Month, D	ay, Year)	47	Count		
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Marr 3 🏿 Widowed	Type in U.S. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur 1 Yes 2 No Specify:					to Disease stall			ace - American Indian, lack, White, etc. White				
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ould be find Menta marked matic ev		Antho		Gerald I			Audrey Shirley Balti					Baltimore	<u>∍</u>		
and 2 sho lealth an em 27 is her trau		19a. Informant's Name/Relationship (Type, Print) Shelton Jackson /Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 Slacum St. Cambridge MD 21613													
Page 1 anent of Hant of Hant: If ite		20a. Method of Disp 1 ☐ Burial 2 4 ☐ Donation	☐ Cremation	3 🙀 Removal from State Specify)		Place of Dispo cemetery, cren Sedal (ill Cem	6/22/	20c. l	Location L	- City or To Lnder		
permit. Departi Import any inji		21. Signature of Fu	neral Service L	Licensee Victor	Dod	a 22	Name an harl	d Addres	s of Facility Stev Fort Av	ens Fu	ner	al H	Home,	Inc.	
				complications that cause								10 1		Approximate Interval Between	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours are death. To the Funeral Director After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the but the funeral director, page 2.	Physician/Medical	23b. Was decedent in the past 12 I 1 Yes 2 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	Ectopic Other (s.f.		у		23d. Date of delivery Month Day Year			*				
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sician: The law certificate has b irector, page 2 s	Completed			aut per	prior to completion of cause of death? 1 □ Yes 2 □ No										
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talor Att rsaterd al Direct ed it by	al Cert	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)									on (Street and Number or Rural Route Number, Town, State)				
ne Hospi n 24 hou ne Funer pleted fill	Medical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due to the cause(s) and manner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner.												use(s) and manner state	ed.
To the To the Com		29b. Signature and title of certifier					29c. License number				29d. Date signed (Month, Day, Year				
•		30. Name and address of person who completed cause of d				DO P2210-					(6/13/11			
/		Elizabe	ess of person HURU	wno completed cause of coopers	death (Item	n 23a) (Type, P 22 S. <i>(</i> -	rint)	ne	St. B.	utima	æ	MD	2/3	-01	
Stat Registra		31. Date filed (Mont	h, Day, Year)	ccobeno D 32. Registr	rar's Signa	barke	ĵ		<u> </u>						_
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 201 **Examiner** Town, or Location of Death 4c. County of Death 1 timor arka **Funeral** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 **X**M 2 □ F Months Days Hours Min. Nº Carolina Director Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at. or 28a-f show 10b. County 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 □ No 10q. Citizen of What Country? Funeral 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black White, etc. þ 1 \square Never Married 2 \square Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) nday (0-12) College (1-4 or 5+) 1 and 2 should be filed within thealth and Mental Hygiens item 27 is marked other the Be her's Name (First, Middle, Last) Relationship (Type, City or Town, State, Zip Code) 19b. Mailin permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Other (Specify) Signature of Funeral Service Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. ich as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician LIVER CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Physician/Medical Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year 4 Pregnant : 9 Unknown Pregnant at time of death 1 Yes 2 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy performe Yes 1 🗌 Yes director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner better free best of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner as stated. (Check 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 32: Registrar's Signature Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item# 14. per fh, g916 6-27-11 sm State of Maryland / Department of Health and Mental Hygiene _ State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Jun 17, 2011 РМ Nicole Jones Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 25, 1975 . Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Months Hours Min 1 M 2 F Yrs Maryland Director 214-02-4428 36 Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No Annapolis Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21401 111 Clay Street 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ð 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify If Yes, Give Year or Dates White Black 3 Widowed 4 Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industr (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home and Mental Hygiene. is marked other tha Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Diane Brown Herbert Jones, Sr. permit, Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Clay Street Annapolis, Maryland 21401 Diane Brown 20a. Method of Disposition 20h. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 👿 Cremation 3 🗆 Removal from State Catonsville, Maryland 06/23/11 4 ☐ Donation 5 ☐ Ther (Specify) Metro Crematory, Inc. 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21 Part 1. Enter the disease, or complications that caused sheek, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): sician and burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the detached 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medica filled in by the funeral director, Be 26. Place of Death (Check only one) xaminer? Hospita Other: ٩ 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred after death. Director: After 5 Pending work?
1 Yes 2 No 1 Natural injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State within 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month JOHN SON Physician/ 46 ゴロム 2011 HERBERT Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Howard County General Hospital Columbia **Howard** Birthplace (State or Foreign Country) 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under **Funeral** (Month, Day, Year) Hours Days Min 1 🔀 M 2 🗆 F 219-26-1284 Director Jul 26, 1940 No. Carolina Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland **Baltimore City** Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 3643 Gelston Drive U.S.A 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? 1 Never Married 2 X Married Yes, Give 2 🗌 No ģ Baltimore, Maryland 21215-0036 1960 1 ☐ Yes 2 🗙 No Specify: Black 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 1963 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Greyhound Bus Company Baggage Dept. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Eliza Johnson William R. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3643 Gelston Drive Baltimore, Maryland 21229 Beverly Johnson 20c. Location - City or Town, State 20h Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 06/28/11 Owings Mills, Md 4 Donation 5 Other (Specify) Garrison Forest Veterans Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION Ph_sician/ MYOCARDIAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HRONIZ Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or The law requires that the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? been signed by the atte Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe page 2 s certificate has death? Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 🐼 No 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpa After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 2 Natural 5 Pending 1 Yes 2 No Investigation n 24 hours after death te Funeral Director: A bleted filled in by the f Accident 3 Suicide 4 Homicide 6 Could not be 28f, Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 [only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 18 2011 Rech 025004 evcen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m021044 HOWARD CO HOSP E.O. KWCK 31. Date filed (Month, Day, Year) State back Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 20040 State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jyrthe 16 pa 2011 Year 10:37a Jacomini Physician/ Omar Joslin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 2 Seward Drive Severna Park 8. Date of Birth (Month, Day, May 24 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Social Security Number **Funeral** ·1925 Months Hours 1 🏻 M 2 🗆 F Ohio 571-40-4993 86 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b County Director 1 Yes 2 □ No Hobe Sound FL. Martin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 9075 S.E. Harbor Island 33455 USA 12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 1946

If Yes, Give 1948 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: 1948 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5 **+** Elementary/Seconday (0-12) Electric Electrical Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence Joslin Jacomini Marcus 19a. Informant's Name/Relationship Twose Print) ator, Co-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 E. Warner Rd. Suite 4 Chandler, AZ. 85225 Leslie Mann-Damon/Guardian Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Bunal 2 X Cremation 3 Removal from State Chesapeake Crem. 6/18/2011 Beltsville, Md. 4 Donation 5 Other (Specify) PHATEATPANDS RENALDI FUNERAL SERVICE, P.A. 21. Signature of Fyneral Service Licensee 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Onset and Death Immediate Cause (Final disease or condition Parkinson's DISEASE Priysiciani Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Eather Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Day Month Year in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 In Nursing Home 3 Knesidence 6XXOther (Specify) Residence 2 (No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D5753 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 N 2 3 2011 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Per DVR G916 6/23/2011 JH State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 June 3:20 A. M 18, Richard Clayton Johnson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Kensington Kensington Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplade figter foreign **Funeral** July 7,1935 Months Days Hours Columbia 216-64-7396 55 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director 1 Yes 2 No Maryland| Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n U.S.A. Funeral 21771 6507 Carrie Lynn Court 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Examiner Black, White, etc. ò 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White "natural" 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Medical Office Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emma L. Hindman Merel L. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry L. Johnson 6507 Carrie Lyn Court, Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 6-20-11 Ardent Cremation, Inc. Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CIREBRAL VASCULAR Ph_sician/ disease or condition resulting in death) Medical Examiner IMMUNUDEFICIENCY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown q | | I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🛩No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy performed? Yes 2 No death? 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 M No ပ္ 1 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After of completed filled in by the funeral 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20057124 6/16/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bao 10110 Molecular Drive #206 Rockville, MD 20850 Truong 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 2011 SOHNSON 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner BALTIMORE MILTORD MANOR Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday 8. Date of Birth (Month, Day, 6. Sex **Funeral** 1 M 2 F Hours 169-32-8130 Yrs Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits City, Town or Location 10a. State 10b. County Department of Heatth and Mental Hygiene. Important: 'or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 ☑ No \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry un 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) social security adm 12 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be gladys Hayes Joseph Golback ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 923 E. Sharprack Street Philadelphia, PA 19150 Harold Golback/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state Funeral Sylice Licensee S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Signature 23a. Part 1 Enter the disease, or complications that caused the death. shock or heart failure. List only one cause on each in a shock or heart failure. Do not enter the mode of dvino Immediate C (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequent **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, attending pl IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnapt 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mon Month Day Year certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to beath but not resulting in the underlying cause given in Part I. Division of Vital Records, Medical Certification: To Be Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physiclan: funeral director. 25. Was case referred to medical examiner? 26. Place o ath (Check only one) 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manuar of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the completely (Check only one) er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person 838 (Neeno

State Registrar 31. Date filed (Month, Day,

2 3 2011

DHMH 17 Rev 7/2009

amend I tem# 26 per phy 916 6723-11 Sm State of Maryland Department of Health and Mental Hygiene 2006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EUGENE KEYES KENNETH 0437 AM me Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CENTER MERITUS MEDICAL HACERSTOWN WASHINGTON 6. Sex 1 M 2 D F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 215-36-5854 Director Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD WASHINGTON HAGERSTOWN 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code 10a. Citizen of What Country? Funeral CHARLES 21740 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces? Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) GUARD HOTELS SECURITY Ith and Mental Hygien 27 is marked other the traumatic event, the 12 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ERANK KEYES SNIVELY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (DAU) NORMA POMFEY CHARLES ST HAGERSTOWN MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or c 1 Burial 2 ☐ Cremation 3 ☐ Removal from State JUNE 16, 2011 HAGERSTOWN MD 4 Donation 5 Other (Specify) ROSEHILL CEM. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility GARY L. ROLLINS FUN IHOME saw 2. 110 WEST SOUTH ST FREDERICK MO 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ nenomi disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying
Cause (Disease or linjury -transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician a sthe burial-1 Physician/Medical Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? Yes 2 No 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 3 Suicide 5 Pending To the Hospital or Atterium, within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a nd title of certifier Conten ause of death (Item 23a) (Type, Print) null 368 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per fh 916 6-24-11 yt State of Maryland / Department of Health and Mental Hygiene 20045 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month LATRINA LACEY MARLE 0427 234 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death HOWARD CONTY GONDERN MORETA Corumaia Confucil If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 1 □ M 2√ F Months Min. 44 2 /5"/1967 **Director** IfTinois 559-33-3066 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-4 any injury or other traumatic avant the second s 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Howard Clarksville 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6111 Rippling Tides Terrace 21029 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Housewife Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Ellis Collins <u>Jennetta Bridges</u> 19a. Informant's Name/Relationship (Type, Print)

Anthony Lacy/Husband 19b, Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code)
6111 Rippling Tides Terrace
Clarksville, Maryland 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulanev Valley 6/18/2011 Timonium, MD Signature of Funeral Service Licenses 22. Name and Address of FacilityLatney's Funeral Home, Inc. cc0278 GEorgia Ave. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ACUTE ROLPIRATORY FARWRE disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner METASTATI-C BROAST comete ZY WNZ Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed CANZER BILLIAST resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Day Month Year 9 Unknown 9 I Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by portunition 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should I ANDSARLA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIAGETES MELLITS performed? Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: မြ 1 Ampatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) عار 1)36974 DIVID 12 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0. NYANTOM MO 10710 CHARESTE DR # 310 wungin no 21544 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 3 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per INF G922 12/21/2011 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2011 UNE George William Lynch Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death SUPME BEHINGTON MEDILAL **Funeral** 8. Date of Birth Birthplace (State or Foreign 1 🗓 M 2 🗆 F Months Days Hours Min. Octonth Oay, Yan 33 Marvland **Director** 77 Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at Page 1 and 2 should , is filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Anne Arundel Riviera Beach 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 238 Meadow Road 21122 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No Specify: If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates. ed other than "natu event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) plumber home improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George William Lynch Sr. Marie C. Divien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7926 E. End Dr; Baltimore, Maryland 21226 Mary Presley - daughter Baltimore, we ortant: If item. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) per it. Departm Importa any inju Signature of Funeral Solvice Licensee Ronald S. W 22. Name and Address of FacilityState Anatomy Board 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Part I. Enter the disease, or con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Quee (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate Examine if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events signed by the attending physician and dbe detached for use as the burial-tran resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably Completed 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 1 ☐ Yes 2 ☐ No 2 the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manno of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred ■ Natural (Month, Day, Year) 5 Pending Accident 1 Yes 2 No within 24 hours after death

To the Funeral Director; ,
completed filled in by the 2 Accident
3 Suicide
4 Homicide Investigation 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and manner stated.

Certifying Nursis Fractioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and the number as stated. (Check only one 29b. Signat d title of certi 29d. Date signed (Month, Day, Year) W() 45149 une completed cause of death (Item 23a) (Type, Print) drive Glen Burnie octal 301 31. Date filed (Month, Day, Ye r) State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June Kenneth Stanley McKoy 2011 7:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3546 Lower Mill Court Ellicott City Howard 8. Date of Birth (Month, Day, July 21 **Funeral** Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign Min. 1 **X** M 2 □ F Hours Country) Marvland 56 **Director** 214-54-0895 Usual Residence of Decedent 28a-f show should be filed within 72 hours after death with the Manyland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho: "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? Funeral 3546 Lower Mill Court 21043 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4X Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Appraiser Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Larry Horace Mckoy Virgina Muriel Veira 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jaana Myllyluoma, Friend 2707 Manhattan Avenue Baltimore, Maryland 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 06/24/11 Baltimore, Maryland . Signature of Funeral Service Licensee Cremation Society Of Maryland 299 Frederick Road Baltimore, Thomas Gregor Maryland, Inc. altimore, Maryland 21228 23a Part 1 Enter the disease of Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. 3 months Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any Louising to the classe. Enter Underlying Directo for as a consequence of Examir sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical the funeral director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work?
1 Yes 2 No after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WCOLE ST AGNES BALTIMORE MO 21229 900 CATON AVE 31. Date filed (Month, Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jume 18, Anne E. Murphy 2011 7:50 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1528 Nicolay Way Essex Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF 073-18-9725 87 Hours Min. Aprillonth, 9ay, Year 24 New York **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Baltimore 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code or than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral 2807 Hoffman Avenue 21227 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian ģ 1 Never Married 2 Married Black, White, etc. Yes Yes 1 ☐ Yes 2 X No Specify Completed 3 XWidowed 4 ☐ Divorced Specify White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) lith and Mental Hygiene.
27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mathiu Romer Catherine E. Reis permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Murphy - Son 870 North Shore Dr., Glen Burnie MD 21060 Baltimore, od of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Barial 2 🖾 Cremation cemetery. matory or other place 4 Donation 5 Other (Specify) crematory 6-20-2011 Glen Burnie, MD 2. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** equalification telligible for the second transfer and the second telligible for the second telli if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Day Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital DAUGHTER 2 X No 은 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 1 Natural 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 Acciden 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2											
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Deatl	h	3. Time of Death		
	Medi	cal	An English Name (Is not be altered)		MOTT	MON	ROE SR		June June	15 2011			
magnet	Examin	ner	4a. Facility Name (if not institution, give s Frederick Memoria		٦		4b. City, Town, o Freder	r Location of Deat	h	4c. County of Deat			
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last b		If Under 1 Year Months Days			9. Bir	thplace (State or Foreign		
	Director		29-42-37/3 1) Usual Residence of Decedent	LIVI Z LI F	66	Yrs.	Welland Baye	riodis iviiii,	OCT. 18	1944 "	untry) M.D.		
	Maryland 28a-f show atified at	Director	10a, State 10b, County FLEDE	RICK	10c. City, To		ation RICK	-			10d. Inside City Limits 1 ✓ Yes 2 ☐ No		
	h with the rs 23a or inst be no	Funeral Di	10e. Street and Number 110 BURGE	SSHILL	WA	7	10f. Zip Code	1702	11	untry?			
9800	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1			/as Decedent of H Yes, specify Cuba	ın, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: BL	e, etc.		
21215-0036	vithin 72 hou iene. r than "natu the Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)	ucation de completed) College (1-4 or 5-		(Give k life. DC	ent's Usual Occup ind of work done of NOT use retired)	during most of wor	king	16b. Kind of Business	Industry		
Maryland 2	tal Hy	To Be	17. Father's Name (First, Middle, Last) THOMAS TUCKER	Monro				18. Mother's Nar	me (First, Middle, M	aiden Surname)	-65		
	1 and 2 should be of Health and Men item 27 is marketother traumatic		19a. Informant's Name/Relationship (Type MEUSSA John		(u) 1	27 t	=not Lt			City or Town, State, Zip			
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)		ceme	tery, crem	ition (Name of atory or other place	(a) June		20c. Location - City or			
Bal	permit Depar Impor any in		21. Signature of Funeral Service License	llis		110	WEST S	DUTH ST	FREDER	LINS FUL UR MD 2			
	hysician/ Medical		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	me	LM	the mode of dying	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death		
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	ecuted and transit	Examiner											
09/	cate be exemply sician at the burial-	dical	d										
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	☐ Fetal dea		Ectopic pregnanc Other (specify)	у		23d. Date of deli Month	very Day Year		
ds, P.O.	quires that I en signed b uld be deta	<u>ک</u>	Part II. Other significant conditions con	tributing to death but	t not resulting	in the un	derlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?		
Division of Vital Records,	The law ate has page 2	Completed							24a. Was an autopsy perform	prior to c ed? death?	opsy findings available ompletion of cause of		
ital	sician: The certificate rector, pag	8	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:			1	ace of Death (Chec	k only one)				
of \	g Physer this eral di	e: To	27. Manner of Death	1 Inpatier 28a. Date of injury	28b.	Time of	3 DOA 28c. Injury	4 ☐ Nursing H	ome 5 Residen 28d. Describe how	ce 6 Other (Special	fy)		
on	endin eath. or: Aft	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	Year)	injury	work'			injury doddinod			
Divis	to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	(Specify)				City or Town,				
;	the Hosp nin 24 hoi the Fune npleted fi	Medical	29a. Certifier (Check 2 Medical Examine only one) 3 Certifying Nurse	er: On the basis of exa	mination and/	or investic	ation, in my opinior	n, death occurred a	t the time, date and	e(s) and manner as state place, and due to the cause(s) and manner as s	ause(s) and manner stated		
	vit 70 cor		29b. Signature and title of certifier	1 Le	N	an	29c. License	1) 35 I	06	d. Date signed (Month,	Day, Year) 2 0 //		
4	İ	1	30. Name and address of person who con	npleted cause of dea	th (Item 23a)	(Type, Pri	nt)	711 6	1 _1 5	- 1	L 21701		
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	Registra	r	JUN 23 ZUII PORT	T									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 1245 PM **Physician** Rita A. McCormack 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Worcester Rerlin Atlantic General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 25, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1942 Months Days Hours Min. 1 □ M 2 🔽 F Maryland 69 Director 215-46-5419 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Department of Health and Mental Hygiene. Income arise useful: Will the Natyla Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Modical Experiment must be redifficed at once. 1 ☐ Yes 2√☐ No Director Berlin MD Worcester ングろ、ン (25/42 DOD: は)しい altimore, Maryland 21215-0036 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21811 USA 26 Burley Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes 2 No Specify: white Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Healthcare Nurse 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rita Brigid Reville Kenneth Anthony Curtis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $26\ Burley\ Street\ Berlin,\ MD \ 21811$ 19a. Informant's Name/Relationship (Type. Print) Christopher McCormack/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 23a. Parl 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate list I had disease or condition resulting in death) State and Address of State and 655 W. Baltimore Street Approximate Interval Between Onset and Death du **Physician** /Medical Examiner 5 Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Jue to (or as a consequence of) oertificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-trar Due to (or as a consequence of). Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No or Auc.
s after death.
al Director: After this ceru...
"> by the funeral director, pe 1 ☐ Yes 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination-and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9733 Heathway 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 24a per verb,g916-06/23/2011dbb
Certificate of Death

Reg. No. 1 - For State Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Richard Lee Naegele Physician/ June 10 2011 Pay 23 43 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore **Examiner** City, Town, or Location of Death Baltimore County Saint Joseph Medical Center . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days XX M 2 G F 215 28 0970 Hours August 31 1930 Baltimore, Maryland 80 **Director** Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner month. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore County 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4210 Overton Avenue 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married X Married þ 1 ☐ Yes XX☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify. 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Land Surveyor Ben Dver Associates 18. Mother's Name *(First, Middle, Maiden Surname)* Marie Collier 17. Father's Name (First, Middle, Last) Joseph A. Naegele 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4210 Overton Avenue Baltimore, Maryland 21236 Marlene E. Naegele (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XX Burial 2 Cremation 3 Removal from State Parkwood Cemetery June 15 2011 Baltimore,Maryland 4 Donation 5 Other (Specify) 21 Si ha re of Funeral Service Licenses Lassann Funeral Flowe Inc 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac br respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lime Immediate Cause (Final Physician/ ronary disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 No 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown urtensian 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 'thin 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: 1 ☐ Inpatient 2 🗷 ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Auatural 5 Pending iniury Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6-13-11 1021022 wili ma

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Mg

BERAIRN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Pfeuffer Bernhard Physician/ J. Month 11:15a^M 6/19 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 29 E. Montgomery Street Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Rirth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Min. (Month, Day, Year) 4/18/47 152-34-7183 1 M 2 🗆 F 64 MD Director Usual Residence of Decedent 28a-f show 10a. State MD 10b County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director N/A Baltimore XX Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 29 E. Montgomery Street 21230 USA ural", or items a 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1X Yes 2 No Army Black, White, etc. Completed by 1 Never Married 2 K Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. White "natural", 3 ☐ Widowed 4 ☐ Divorced Year or Dates. Vietnam injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Plateing Owner of Plateing Co. Be 17. Father's Name (First, Middle, Last)
Bernhard C. 18. Mother's Name (First, Middle, Maiden Surname)
Velma Lutz Pfeuffer ပ 19a. Informant's Name/Relationship (Type, Print)
Patricia A. May/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 E. Montgomery Street, Baltimore MD 21230 f Health airem 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial XXCremation 3 ☐ Removal from State Ardent Crematory 6/23/2011 4 ☐ Donation 5 ☐ Other (Specify) Hanover Maryland Service Licensee Victor Doda 22 Name and Address of Facility tevens Funeral Home, Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Atherosclerosus Physician/ COVENATA disease or condition RAVS Medical resulting in death) Due to (or as a consequence f) **Examiner** Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury -transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: nse > 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f 1 ☐ Yes ≥4.9 ☐ Unknown 9 | Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Vunknown Records, should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes XXNo 2XXNo 1 Tes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗆 No 2| 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, after death.

Director: After this completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1XXNatural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direc 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 44715 6-22-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 ST PAUL BACT MIDZIZOZ 101

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

11-04429	
Floyd Purnell	

Please Type of Frint in Black Indelible Ink. Ensure All Capies Are Legible. 2011 20053
State Daryland / Department of Health and Ment Dygiene

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Funeral		ocial Security N		6. Sex		Age (In yrs. Ia	_	M	Under 1 Year onths Days	If Unde Hours	r 24Hrs. Min.	- 1			Foreign	hplace (State or
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any			10b. County			10c. City,	Town or Lo	cation								10d. Inside City Limits
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5-0036 led within 72 hours al Hygiene, other than "antural the Medical Examin	E 17. I	lementary/Seco	ndary (0-12)		College (1-4 o	or 5+)		-	DIAN			-,	B	ALTO O	CITY	1 ScHOOLS
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D 21215-00; should be filed with and Mental Hygiene. 7 is marked other the natic event, the Med	9a.	Informant's Na	me/Relations	hip (Type,	Print)	11 + 10	19b. Mai	iling Addr	ess (Street	and Numi	ber or Ru	Route N	umber, (City or Towr	n, State,	Zip Code)
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Physician /Medical	23a.	Part I. Enter the failure. List onl		on each li	ne.		Do not ente	er the mo	de of dying, s	uch as ca	rdiac or r	espiratory a	rrest, si	lock, or hea	rt	Approximate Interval Between Onset and Death
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one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed													`			
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Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 701

A Shaheen

6-22-11

M. Challes St. Suite 4105, Baltimere, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Delphine Redfearn		e of Maryland / De		f Health and		giene		20055
Physician/ Medical Examiner	Decedent's Name (First, Middle,L					2. Date of Death Month June 15, 2	n	3. Time of Death 0809 hrs
	4a. Facility Name (if not institution, of 5502 Todd Avenue	edfeam Robinson jve street and number)		4b. City, Town, or Lo		ounc 15, 2	4c. County of Deat	h
Funeral Director	216-54-0865	Sex 7. Age (In y	rs. last birthday) 59 Yrs	Months Dove	If Under 24Hrs. Hours Min.	8. Date of Birt	6(MM/DD/YYYY) 9. Bi Forei Co	
nd klow any ice.	Usual Residence of Decedent 10a. State 10b. County MD n/a	10c. (City, Town or Locat	ion				10d. Inside City Limits 1 XYes 2 No
h the Maryland 3a or 28a-f sh iotified at once	10e. Street and Number 5502 Todd Avenue			10f. Zip Code 2120)6	10	g. Citizen of What Cou USA	ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other transmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorc 15. Decedent's Education (Specify	1 Yes 2 X N ed If Yes, Give Year or Dates:	lo If Y	s Decedent of Hispa es, specify Cuban, M Yes 2 No s t's Usual Occupation	flexican, Puerto R	tican, etc.)	White, etc.	ican Indian, Black, ican-American
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MD 21215-0036 do 2 should be filed within 7 that and Mental Hygiene. m 27 is marked other than anmatic event, the Medica To Be Comple	17. Father's Name (First, Middle, La Wilson Redfearm 19a. Informant's Name/Relationship		19b. Mailing		Mother's Name (F Thelma Box nd Number or Ru	wman	aiden Surname) ber, City or Town, State	a, Zip Code)
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Baltimore, permit Pages I at Department of He Important: If ite injury or other tr	4 Donation 5 Other Speci 21. Signature of Financial Service Lice	fy:				e Funeral	Woodlawn, MD Home P.A. of	Balto. Co.
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funcral Director: After this certificate has been signed by the attending physici or the Funcral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burificatic or to Be Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	23c. If yes, outcome of p 1 Live birth 4 Pregnant at time o 9 Unknown	2 Fel	al death 3	Ectopic pregnanc	;y	23d. Date of delivery Month	Day Year
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that th is after death. In Director: After this certificate has been signed by teld in by the funeral director, page 2 should be detacted artification: To Be Completed by P	examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year)	ER/Outpatient	3 DOA Oth	ner Nursing I	Home 5 R	Residence 6 🗸 Other	: Scene
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Divis To the Hospital or 4 within 24 hours after To the Runeral Dire completely filled in k Medical Certific	one) 2 Medical Examin	clan: To the best of my know er; On the basis of examination and manner stated.	-	on, in my opinion, de	eath occurred at ti	he time, date a	nd place, and due to th	e cause(s)
	29b. Signature and title of certifier	6/1	7 P	O.C.M.I			29d. Date signed (Mod June 20, 2011	ntn, Uay, Year)
12 13	30. Name and address of person who Russell Alexander MD.	Assistant Medical Ex	aminer 900 \	W. Baltimore St	reet, Baltimo	re, MD 212	23	
State Registrar	31. Date filed (Month, Day, Year)	Registrar's Sign	agure frank		OCA	Æ		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Funeral Director		5. Social Security N 448-70	-7854	M 2XF		yrs. la:	st birthday) Yrs	Month	er 1 Year Is Days	If Under Hours	24Hrs. Min.	8. Date of Bir 2 / 8	th (MM/DD/YYYY) / 72	9. Birth Foreign Cou	
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other thas "oatural", or items 23a or 28a-f show injury or other traumatic evec, the Medical Examiner must be notified at loace. The December of the Medical Examiner must be notified at loace.		3 Widowed		1 Yes If Yes, Give Year or Dates:	orces? 2 X	No	1 ['es, speci Yes 2	fy Cuban,	Mexican, I	Puerto R		Amer Specify:	icar Wh	an Indian, Black, Indian
5-0036 led within 72 hours Hygiene. other than "oatun the Medical Exam	npieted	Elementary/Second 1 2		College (1	-4 or 5+)		Nur	ost of wo	rking life. I	on (Give ki DO NOT u Ninis	ise retire	d)	16b. Kind of Bu Hea		care
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Baltimore, oemit. Pages lan Department of Hea Important: Uiter injury or other tri			position Cremation 3 Other Specify		om State	cr	lace of Dispos ematory or ot ohnsor	her place)			Date 111/11	Shawned Johns	City or 1	own, State
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Physician /Medical xaminer	1		ne disease, or comp ily one cause on ea (Final disease a.	ach line.									est, shock, or he v and obe		Approximate Interval Between Onset and Death
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certificate certificate se as the b	Clany	IF FEMALE: 23b. Was decedent past 12 months 1 Yes 2 I	pregnant in the s? No 9 Unknowr	23c. If yes, of Live b	outcome o irth ant at time	of pregn	ancy 2 Fe	etal death ther (Spe	3 [Ectopic			23d. Date of Month	delivery D	ay Year
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of Vital Records, og Physician: The law requir ufter this certificate has been s meral director, page 2 should b	Completed											1 ✔ Yes	osy prmed?		opsy findings available ompletion of cause of s 2 No
Vital ysicians his certi director	e Re	25. Was case refer examiner? 1 ✓ Yes	1 _	Hospital: 1 1	npatient	2 🗸	ER/Outpatien			of Death (nly one) Home 5	Residence 6	Other:	
on of Vi eodiog Physi ath. or: After this the funeral dir	- -	27. Manner of Deat	th 5 Pending	_ '	of Injury , Day,Yaar)		28b. Time of	Injury		at Work?		28d. Describe	how injury occurr	ed	
Division pital or Atteodic ours after death. ceral Director: A filled in by the for	Certification:	2 Accident 3 Suicide 4 Homicide	Investigati 6 Could not determine	be 28e. Place	e of Injury	- At ho	me, farm, stre	et, factor	/, office bu	ilding, etc).	28f. Location (or Town, \$		er or Rur	al Route Number, City
Divisior To the Hospital or Atteod within 24 hours after death yo the Fuoreral Director: completely filled in by the	١٠	29a, Certifier (Check only one) 2	Certifying Physic Medical Examine	r: On the basis of	of examina										
1 (10) 13	₽	29b. Signature and	title of certifier	and manner s	1 1	,	1	29	c. License				29d. Date sign		th, Day, Year)
	-	30. Name and addr Zabiullah Al	ress of person who	completed caus stant Medic				Raltimo			more I	MD 21223			
Stat Registra		31. Date filed (Mon			gistrar's			erker	/	, Dunii					
Registre	Щ,			MILL AND	Section of the second	-	the state of								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06 JOSIE STATEN 2011 6:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Gardens Nursing Home Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days 03-23-1919 Hours Min. Country) Director 226-22-3103 Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2908 REISTERTOWN RD. APT 1J 21215 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces ō þ Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", If Yes, Give 3 XWidowed 4 Divorced Specify Completed BLACK Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5th DOMESTIC DOMESTIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental marked ည MITCHELL T. HARRIS MELVINA LAWRENCE and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trauonce. JOANNA WORRELL/GRANDDAUGHTER 217 S. BALLOU CT. BALTMORE, MD 21231 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specific ZION CEMETERY 06-20-2011 BALTIMORE, MD e of Funeral Service WILLIAM C. BROWN COMMUNITY FUNERAL HOME P.A. 1206 W. NORTH AVE. BALTO., MD 21217 Part 1, Enter the disease Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate causs. Liner Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of Examin attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death signed by the a d be detached t 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed Yes 2 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar alkui

who completed cause of death (Item 23a) (Type Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ime of Death Month Physician/ Lune ELIOTT CHARLES SEIBLES Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ARUNDEL BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Social Security Number **Funeral** Days Hours Min 1**X** M 2 □ F 212-40-3897 70 01-30-194 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director must be notified 1 Yes 2 No 28a-f SEVERN ANN ARUNDEL MDò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a U.S.A. 21144 6444 W. B. & A. ROAD or items Was Deceue... Armed Forces? Ves 24 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 24 If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify Specify: BLACK "natural", 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the TRANSPORTATION DRIVER 10th TRUCK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LULA GREEN EUGENE SEIBLES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traunonce. 513 HALF MILE CT. BALTIMORE, LATONYA N. DARDEN/DAUGHTER MD 21201 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State BALTIMORE, MD 4 Dongtion 5 Other (Specify) RIDGE CEM. 06-27-2011 e of Funeral 22. Name and Address of Faci COMMUNITY EUNERAL HOME P.A. WILLIAM 1206 W. NORTH AVE. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ OVO disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Exam Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached ' Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🖰 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No ည 1 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending work? 1 🗌 Yes Natural 5 Pending 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year una

State Registrar 30. Marne and address of person

Date filed (Month, Day, Year,

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who gon pleted/cause of death (Item 23a) (Typ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2011 Welton 5:23 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner reducal cente citimore Bul timore . Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min. 07-01-1932 1 🖾 M 2 🗆 F Months N.C. Director 78 218-28-8469 Usual Residence of Deceden 10a. State 10b. County 10d. Inside City Limits death with the Maryland or 28a-f shorn 10c. City, Town or Location Director 1 X Yes 2 □ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 3505 ELDORADO AVE. APT B 21207 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 🖾 Yes 2 🗆 No 1950-Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after er than "natural", c If Yes, Give Year or Dates. 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced BLACK 1969 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I AUTOMOTIVE LOT ATTENDANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 MARY GRADY ROGER SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3505 ELDORADO AVE. APT B. BALTIMORE, MD 21207 Important; If item 27 any injury or other to once. MARY B. SMITH/WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 06-27-2011 OWINGS MILLS, MD Forest Vet. Garrison Name and Address of Eacility
LLIAM C. BROWN C
OB W. NORTH AVE. re of Funeral Service 22 Nam WILL 1206 COMMUNITY FUNERAL HOME P.A. E. BALTIMORE, MD 21217 Van Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurer List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Droncry Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has this certificate 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 🗀 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore MD 21201 -reene 31. Date filed (Month, Day, Year) State

Registrar

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Richard John Sorochinski-1- For State Certificate of Death Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Richard John Physician/ Sorochinski Month Day June 20, 2011 0910 hrs Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** 221 International Circle-Marriott Courtyard Hotel **Hunt Valley** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours 143-66-8819 1/25/63 NJ Director Country) 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State NC Indian Trail Union 1XX Yes 2 No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7006 Winding Creek Drive 28079 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 X Married XX No 1 Yes Specify: White If Yes, Give Year 1 Yes 2X No specify: 3 Widowed 4 Divorced ۵ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Computer Install-ation Network Emgineer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Peter Sorochinski William Noreen Mae Schultz Be 19a. Informant's Name/Relationship (Type, Print)
Linda Faye King /Wife ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7006 Winding Creek Dr., Indian Trail NC 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, Stat 20a. Method of Disposition crematory or other place)
Yates Crematory 1 Burial 2 Cremation 3XX Removal from State 6/27/11 Charlotte NC 4 Donation 5 Other Specify: Name and Address of Facility harles L. Stevens Funeral Home, 501 E. Fort Avenue, Baltimore MD 21. Signature of Funeral Service Licensee Doda 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death a. Multiple Cutting Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical x AMENDED 28a,b per me g918 8-30-11 vt UNPENDED attending physician or use as the burial -Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Month Year 2 Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e, Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Certification: To Be Completed

e Hospital or Attending Physician: The law r 124 hours after death. e Funeral Director: After this certificate has b etely filled in by the funeral director, page 2 sh within 2

		Was an autopsy performed? Yes 2 ✓ No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 ✓ No					
25. Was case referred to medical	26.Place of Death (Check only one)						
examiner? 1 ✓ Yes 2 No		5 Residence 6 ✔ Other: Scene					
27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	ng Jun 20, 2011 ear) Id • 0900 hrs fd • 1 Yes 2 ✓ No Subject	cribe how injury occurred t cut self					
3 Suicide 6 Could n 4 Homicide	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Loca or To	28f. Location (Street and Number or Rural Route Number, City or Town, State) 221 International Circle, Hunt Valley, MD					
OD- Ordifor	vsician: To the best of my knowledge, death occurred at the time, date and place, and due to the						

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD.

and manner stated.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

OCME

29d. Date signed (Month, Day, Year)

June 21, 2011

31. Date filed (Month, Day, Year) Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

Medical

State

Registrar

29b. Signature and title of certified

11-04610 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dexter Ray Spear State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Dexter Ray Spear Jr. 0202 hrs Medical Examiner June 20, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Nottingham **Baltimore County** 47 Henry Avenue 5. Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 218-94-0882 Months Days Hours Min Director June19,196 MD Country) 1 X M 2 F 44 Usual Residence of Deceden 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location MD Baltimore 1 Yes 2 No Baltimore or 28a-f show other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. and 2 should be filed within 72 hours after death with the Maryland Director 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 47 Henry Avenue 21236 USA Funeral 11. Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes White 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 X No specify: Specify: à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Service Tech Allied Phillips Baltimore, MD 21215-0036 12th ment of Health and Mental Hygiene.

Taot: If item 27 is marked other th
or other traumatic eveot. the Medi 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Dexter R. Spear Sr. Be Peggy L. Hewitt 19a. Informant's Name/Relationship (Type, Print) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa L. Spear /wife 47 Henry Avenue Baltimore MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 2 X Cremation 3 Removal from State Bayview Crematory 6/22/11 Baltimore MD Donation 5 Other Specify 22. Name and Address of Facility Name and Address of Facility 300 Mace Avenue Balto, MD Connelly Funeral Home of Essex 21221 Signajure of Funeral Service Licensee e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line /Medical a Intraoral Shotgun Wound Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit sician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy 2 Fetal death 1 Live birth Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown icate has been signed by the page 2 should be detached: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed death? ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient 2 ER/Outpatient 3 DOA ✓ Yes 28a. Date of Injury (Month, Day,Year) FOUND: After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Subject shot self FOUND: Natura 5 Pending 1 Yes 2 ✔ No within 24 hours after death. in by the Jun 20, 2011 0155 hrs 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 47 Henry Avenue, Nottingham, MD (Specify) Garage Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 20, 2011

State Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

OCME

32. Registrar's Signature

Carol Allan, MD

900 W. Baltimore Street, Baltimore, MD 21223

PONNIE DEION STEIGHT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # State of Mary and Department of the State of Mary and the Property of the State of Mary and the Property of the State of Mary and the Property of the State of Mary and the State of Unk Unk 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 26, 2011 1703 hrs Medical Examiner RONNIE DEION STEICHT Ronnie Deon Speight, JR 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Prince Georges Hospital Center Cheverly If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Washington, Country)DC Hours Months Days Director January 26, 1991 1 X M 2 F 20 577-21-0384 Usual Residence of Decedent 10d. Inside City Limits any 10c. City, Town or Location 1 X Yes 2 No "natural", or items 23a or 28a-f show Examiner must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If them 27 is marked other than "natural", or items 23s or 28s-f she or other tramantic event, the Medical Examiner must be notified at one. Washington Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1131 Girard Street, NW 20009 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 1 Yes 2 X No 4 Divorced If Yes, Give Year Specify: Black 3 Widowed 1 Yes 2 X No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Private 12th Carpentry 17. Father's Name (First Middle, Last) **Speight**Ronnie Steight 18.Mother's Name (First, Middle, Maiden Surname) 8 Dionne Short 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Steight - Father 731 Jefferson St., NW, Washington, DC 20011 Ronnie 20a. Method of Disposition 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, timore, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State Important: 1 06/04/2011 Landover, Maryland Harmony Memorial 4 Donation 5 Other Specify. 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service bicense 716 Kennedy Street, NW, Washington, DC 20011 tion that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23. Part I. Enter the disease, **Physician** Between Onset and failure. List only one caus on each line. /Medical Death a. Multiple Gunshot Wounds Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Hospital or Attending Physician: The law requires that the death certificate be executed d. Physician/Medical g physician a the burial -UNPENDED AMENDED Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ed by the a detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ 1 Yes 2 No 3 Probably 4 Unknown σ. Completed Records. 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy After this certificate has funeral director, page 2 sl performed? death? 2 No i ✔ Yes 2 No 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Division of Vital Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: 1 Yes 28a. Date of Injury (Month, Day, Year) May 26, 2011 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Injury Certification: To the Hosp...
within 24 hours after deau.
To the Funeral Director: Af Subject shot 1 Natural 1625 hrs 5 Pending 1 Yes 2 V No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 5104 J Street NE , Washington , DC (Specify) Alley determined 4 🗸 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. May 27, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) Registrar's Signatur State

DHMH 17 Rev 1/2001

Registrar

OCME

23

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 26 per dvr,g916,06/23/2011dhb
Certificate of Death
Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth Mary Surguy June 2011 11:20p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Baltimore 624 Bowleys Quarters Road Middle River Social Security Number 219-07-1290 **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country 1 M 2 XF Months Days Aug. 31 95 Hours **Director** 1915 Usual Residence of Decedent "natural", or items 23a or 28a-f shov idical Examiner must be notified at death with the Maryland 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Middle River MD Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6618 Ebenezer Road 21220 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No þ Black, White, etc. should be filed within 72 hours after of and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☐ No Specify Completed 3X Widowed 4 ☐ Divorced Specify: White Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frederic Buschman Elizabeth Schoeberlein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant; If item 27 i Shirley Ellsworth /neice 624 Bowleys Ouarters Road Baltimore MD or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State HoTTy "HITT" "Cemetery 4 Donation 5 Other (Specify) 6/16/11 Baltimore MD 21. Signature Fundal Service Lib 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 or const 23a. Part 1. Enter the disease cations that cause e cause on each lin eath. Do not enter the mode of dying such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final disease or condition Onset and Death Physician/ Year Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events at ending physician and for use s the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 5 Dasidence 6 X Other (Specify 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral. 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 10 Natural 5 Pending injury 2 Accident Investigation 1 Tes 2 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) P 29c. License numbe 29d. Date signed (Month, Day, Year) 0 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 metrmore LUX4477 31. Date filed (Month, Day, State Registrar's Signatu 2 3 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Dorothy Szymanski 2011 PM M Medical June 30 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital <u>Takoma Park</u> Montgomery 5. Social Security Number unk 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 💢 F Months Days Hours Min. (Month, Day, Director 75 Jan Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 Yes 2 X No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7355 E. Furnace Branch Road 21061 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 Divorced Specify: white Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk un 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Surname) ၉ and 2 should by Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington Adventist Hospital 7600 Carroll Avenue Takoma Park, MD permit, Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☒ Other (Specify) in state 21. Signature of Euneral Service Licensee
Ronald S Wad 22 Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pa 1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. k, or heart failure. List only one cause on each line. Approximate Interval Between Immediat See (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of) Exam that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month 1 Yes 2 9 Unknown ed by the a s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes 2 14No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: ည 2 KMO 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. 2 Accident
3 Suicide Investigation completed filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 00060100 06-13-1

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

BLUD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Baltimore, Maryland 21215-0036	es 1 end 2 should be filed withir of Health and Mental Hyglene. I flem 27 is marked other then r other treumatic event, the M		19a. Informant's Name/F				19b. Maili	ng Address	(Street a				ber, City	or Town, Sta	te, Zip Cod	e)
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ο, L	The law requires that the death certifica lie hes been signed by the ettending ph page 2 should be detached for use as th	by P	Part II. Other significant	conditions co	ntributing to death I	but not res	ulting in the u	nderlying ca	use give	n Part I.		23e. Die	tobacco	use contribu	te to the ca	use of death?
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to	Phys this ral dir	₽.	1 ☐ Yes 2 No 27. Manner of Death		Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence									Specify)		
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<u> S</u>	Attendi r death. ector: A by the fu	ifica	3 ☐ Suivide 6 [Could not be	28e. Place of In	jury - At he	ome, farm, str				-	28f. Location	(Street a	and Number o	or Rural Rou	ute Number.
ā	s afte	Certification:	4 Homicide	/	building, e	tc. (Specif	y)					City or T	own, Stat	te)		
	To the Hospital or Attending Physicien: while 24 hours after death. To the Funerel Director: After this certificacompletely filled in by the funeral director.		29a. Certilier (Chec only 2	Certifying Phy	sician: To the best	of my kno	wledge, deat	h occurred a	t the tim	e, date an	d place, a	and due to th	e cause(s	s) and manne	er as stated.	
	To the H within 24 To the Fi complete	ledical	one)	Medical Exami	ner: On the basis of and manner si	or examina	tion and/or n	vestigation,	in my op	inion, dea	th occurre	ed at the tim	e, date an	nd place, and	due to the	cause(s)
	To To	Σ	29b. Signature and title of	of certifier	11.0	100		29c.	License	number	p 179		29d. Da	ate signed (A	fonth, Day,	Year)
			1		MI	1		12	100	450	251		Sur	ne que	100	('
			30. Name and address of	person who co	empleted cause of		23a) (Type.	Print)	ml	ret	em	87	Ha	MARC	TOTIMI	MD 21746
	Sta	te	31. Date filed (Month, Da	y, Year)	32. Regist			- 4	, .				V 1 5	IUIUKS	~WV	777
, č	Registr		JUN 2	3 2011	Denisa	. A.	fact							-		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 24a,25,26,27,30 per dr. 2916,06/23/2011dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 11:48 AM 23 May Mary E. Trego Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cecil 3760 Telegraph Road #5 Elkton If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2 🙀 F Months Hours May 26, 1921 Director 89 219-10-8725 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Tes 2 No Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 USA 3760 Telegraph Road #5 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 💢 No Specify: white Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) manufacturing assembler Be 17. Father's Name (First, Middle, Last) Should be file in and Mental H 7 is marked of 18. Mother's Name (First, Middle, Maiden Surname) Ethel Hilman Robert Goodyear 19a. Informant's Name/Relationship (Type, Print) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cecil County Dept of Social Svc 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☒ Other (Specify) in state Significant of Euneral Service Licenting the Roma of Service Licen ,/Director State Anatomy Board 655 W. Baltimore Street Baltimore. MD 21201 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Athersdortin Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Vacentrolles Securation of any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [출 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has build in the sector, page 2 sector in the sector in th autopsy 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No ဂ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00069207 5/23/1

Registrar

State

Registrar's Signature

106 Bow St., Elkton, MD 21921

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Savio, M.D.,

JUN 2 3 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Ella Mae Barnes Tarbert Mrathe 21, 2011 1:10 P. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Manor Care Roland Park Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days 1 □ M 2XX F Min Month Day Yes 215-14-5334 89 Mary Land Yrs. Director Usual Residence of Decedent "natural", or items 23a or 28a-f show sdical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No N/ABaltimore Maryland Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3715 Keswick Road 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2 KKNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry uld be filed within ...
d Mental Hygiene. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Telephone Company Service Representative marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eunice Maude Davies Harry Clinton Barnes should and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit, Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other trau 3715 Keswick Road, Baltimore, Maryland 21211 Daughter Marylu Tarbert 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation A Donation Other (Specifin tombrent 6/23/2011 Dulaney Valley Memorial Timonium, Maryland 22 Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland Signature of Fundal Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition o PP Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last and trar Due to (or as a consequence of): attending physician if or use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Year 1 Yes 2 D Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 TYes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide injury work?
1 Yes 2 No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

8M State 29b. Signature and title of certifi

31. Date filed (Month, Day, Year)

2 3 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

log about

Box 68760

P.O.

Registrar DHMH 17 Rev 7/2009 8813 Waltham

32. Registrar's Signature

29c. License number

D0069314

Parlculle

Woods Rd

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh. 30 per dyr g916 6-23-11 yr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Susie Thomas June 2011 10:30 A™ 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Thomas Moore Medical Complex Prince George's Hvattsville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8 Date of Birth **Funeral** March 3, 1927 1 □ M 2X F Min Mississippi Director 414-36-9395 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director X☐ Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 807 East Belvedere Avenue 21212 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business Industry Memphis 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Furniture Factory Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked of မ Virginia Lester Robert Thomas, Sr. permit. Page 1 and 2 should Department of Health and M Important. If item 27 is mar any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 East Belvedere Avenue, Baltimore, Maryland 21212 Charles E. thomas 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Park Cemetery 6-25-11 Memphis, Tennessee 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. Signature of Funeral Service Licenses michael 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Althero sclero tu Immediate Cause (Final Physician/ Cardinascular disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death,

To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2 s autopsy performe 1 Yes No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 2 No ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00063681 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1835 University Blvd. E. #208 Hyattsville, Md. 20783 Ajit Kurup 31. Date filed (Marith, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 3. Time of Death 1:30a 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Margaret J. Della Vecchia 20 2 0°4°1 June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Abingdon c. County of Death Harford 3602 Skipjack Court Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 213-60-4075 Days June 25, 1955 1 🗆 M 2 🕱 F 55 Yrs. MD **Director** Usual Residence of Decedent 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Abingdon MD Harford 1 ☐ Yes 2 ☐**X**No 10e. Street and Number 10f. Zip Code 21009 10g. Citizen of What Country? Funeral 3602 Skipjack Court USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 24 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12th \end{array}$ College (1-4 or 5+) own home Homemaker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Erma Komber Fred Hartmann Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Anthony Della Vecchia /husband 3602 Skipjack Court Abingdon MD 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Bayview Crematory 6/21/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Acw. Balto. MD Connelly Funeral Home of Essex 21221 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Interval Between Immediate Cause (Final Onset and Death Ph_sician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident $5 \square$ Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and the 29d. Date signed (Month, Day, Year) 20/2011 8 M who completed cause of death (Item 23a) (Type, Print) State Registrar

Sas

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Day 2011 Year June 13, **Physician** 7:55 PM M Carl VanHorn /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Aberdeen 116 Kretlo Drive If Under 1 Year | If Under 24 Hrs. 5. Social Security Number unk 6. Sex 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M M 2 □ F unk Director 67 May 22, 1944 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ral", or items 23a or 28a-f show Examiner must be notified at Director 1 ☐ Yes 2 No MD Harford Aberdeen 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with Inent of Health and Mental Hygiene. 21001 USA 116 Kretlo Drive by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 □ Yes 2 □ No U
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc unk 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐Yes 2 🛱 No Specify. white 3 Widowed 4 Divorced Completed unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) unk unk permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygin Important: If item 27 Is marked other any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be unk 2 unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harford County Poilice Dept 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 📉 Other (Specify) in state 21. Signature of Funeral Service 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 Director 655 W. Baltimore Street Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) TYes 2 No. 9 Unknown as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy 2 **2** No 1 ☐ Yes 2 No 25. Was case referred to erical examiner? 1 ☐ Yes Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 No 2 No Certification: To After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. Il Director: / 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of cortifie

MROWITEC

Aberdeen

who completed cause of death (Item 23a) (Type, Print)

16

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20 11 Physician/ Sylvia Weinberg 7:09 ам June 17, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bethesda Health and Rehabilitation Bethesda Mortgomery 8. Date of Birth (Month, Day, Year) Dec 19,1918 Social Security Number Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Days Min. 1 🗆 M 2 🔀 F Hours 92 Director 148-38-8382 NY Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 ☐ No MD Montgomery Potomac 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10109 Logan Drive 02854 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. O. ģ 1 Never Married 2 Married ☐ Yes 2 🛛 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White If Yes, Give "natural", 3 X Widowed 4 Divorced Completed Year or Dates traumatic event, the Me #cal 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harry Gordon Sadie Blumenthal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Stave-Samuels 10109 Logan Drive, Potomac, MD02854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Mt. Lebanon 1 X Burial 2 Cremation 3 Removal from State 6-18-2011 Woodbridge, NJ 4 ☐ Donation 5 ☐ Other (Specify) Cemeter 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Lehrer-Gibilisco Funeral Home 275 West Milton Avenue, Rahway, NJ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ van disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month s been signed by the should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? 2/1 No Hospital မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending work? s after death.
I Director: Af 2 No 2 Accident
3 Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the within 2 To the F 3 😾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier ho completed cause death (Item 23a) 01 10 14/41 32. Registrar's State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Maryland		artment of Hertificate of D			iene	20072
	Physici	an	1. Decedent's Name (First, Middle, La	ILLIAMS	-			2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or I	ocation of Death	100,	4c. County of Dea	
	Zamini	Ŭ.	HOLY CRO	SS HOSPITE	1+	SILVER		SUL	MONTG	OMERY
	Funeral Director		115-22-4036	Fex 20 F 7. Age (In yrs. la	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	(, Year) 9. Bi	rthplace (State or Foreign ountry)
	ow ow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	e-f sh	tor	MD HOWA	RD CO CO	LUM	BILA				1 10 Yes 2 □ No
	or 28	Dire	10e. Street and Number			10f. Zip Code			log. Citizen of What C	
	s 23e	eral		12. Was Decedent Ever in U.S		Mas Decedent of His	ty Origin? (Si	necify Ves or No-	14. Race - Am	
36	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or Itams 23a or 28a-f show ent, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No		Was Decedent of His f Yes, specify Cuban 1 Yes 2 No		Rican, etc.)	Black, Wh	
21215-0036	2 hour	ted t	15. Decedent's E	Year or Dates: UN K	16a. Dece	dent's Usual Occupa	tion		16b. Kind of Busines	s/industry
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7	led wil ygien her th	Con	UNK	UNK		UNV		(5	UNK	
and	d be fil ntal H ed otl	Be C	17. Father's Name (First, Middle, Last	,			18. Mothers Nan		Maiden Sumame)	
Maryland	should nd Me mark matic	ပ္	19a. Informant's Name/Relationship	Type, Print)	19b. Mailir	ng Address (Street a	nd Number or Ru	ral Route Numbe	r, City or Town, State,	Zip Code)
	alth ar		HOLY CROSS	HOSPITAL	120	O POR	EST 61	EN S.	S. MD	20902
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Important: If item 27 is marked other than "natural; or Itams 23e or 28e-f show any follory or other treumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec)	20b. Pla Removal from State	ace of Dispo	sition (Name of matory or other place	1	Date	20c. Location - City of	r Town, State
Balti	permit. Departm importa any inju		21. Signature of Funeral Service Lice Ronal d	Wade Fixector	/				omy Board	21201
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not ent	er the mode of dying	, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final) disease or condition	FUEUM	ONI	A				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):		1			
L		-e	Sequentially list conditions, if any, leading to immediate	b. PLBURY		EFFUS	1001			
**	uted, d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. CEREBRA	CIDER	72				
8760,	icate be executed, physicien and the burial-transit	Ical Exa	resulting in death) Last	Due to (or as a consequ						
9	tificate g phy: as the				-					
P.O. Box	ath cer ittendin or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown		23d. Date of d Month	. Date of delivery Month Day Year			
	ires that the de signed by the a d be detached f	by	Part II. Other significant conditions	contributing to death but not resu	lting in the u	nderlying cause give	n in Part I.			to the cause of death?
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Division	l or Attending after death. Director: After I in by the fune	flca	2 Accident investigated 3 Suicide 6 Could not to	28e. Place of Injury - At ho	me, farm, st		30 20.10		Street and Number or	Rural Route Number,
2	in the	Certification;	4 Homicide	building, etc. (Specify)	,		City or Tov	vn, State)	
	To the Hospital or Attant within 24 hours after deat! To the Funeral Director: completely filled in by the	edical (29a. Certifier 1 Certifying P (Check only one) 1 Medicel Exe	hysicien: To the best of my know miner: On the basis of examinat and manner stated.	wledge, deat ion and/or in	h occurred at the tim vestigation, in my op	e, date and place inion, death occu	a, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mo	nth, Day, Year)
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			30. Name and address of person who	4				27 A . A	2 2 2	M & 000:-
	Sta	to.	DR KANWY 31. Date filed (Month, Pay Year)	32. Registrar's Signat	ure 🎍	500 FO	WEST G	SLEW R	10 27.	MD. 20910
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Bro iana orse 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, O8 - 21) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director lary land Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No ΜD Director aroline eston 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 55 24304 216 by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Counselor St. Benedictine-School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Nar eon rsey ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. N LVOTY Treston 20b. Place of Disposition (Name of cemetery, crematory or other plaqe) 20a. Method of Disposition 20c. Location - City of 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) ō 3 Removal from State 06-11-2011 Preston (Jonestown) Md. 21. Signature of Funeral Service Licenses 22. Name and Addre 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to firm ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) ate has been signed by the at page 2 should be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 200 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 No completely filled in by the funeral director, 26. Place of Death (Check only one Be Hospital: Other: 4 \sum Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence မ 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation or Attending Natural Injury 1 🗌 Yes 2 No Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NKUR 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, State

8th |

DHMH 17 Rev 1/2001

Registrar

JUN 07 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Eleanore В. Barton 11:00P M 2011 Medical June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 8. Date of Birth (Month, Day, May 12 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Months Days Min. Hours 577-50-4253 77 Washington, D.C. Director Vrs 1934 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified Md. Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r 20906 14514 Kelmscot Drive United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ò þ 1 Never Married 2 Married Yes, Give 2 🔀 No Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: "natural", Completed Specify: White Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ilth and Mental F 27 is marked of r traumatic ever ge 1 and 2 should be fil it of Health and Mental : If item 27 is marked ည Buckley Rernard Ostmann Trene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20855 Brian Barton / Son 19816 Meredith Drive, Derwood, Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/9/2011 Md. Gate of Heaven Cem. Silver Spring, 21. Signature of Funeral Service Licenses Name and Address of Facility
Muriel H. Barber
P. O. Box 5038, Funeral Home Laytonsville, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ COVERCEYY disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performed? certificate 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: ပ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completed filled in by the ft 2 Accident
3 Suicide Investigation M 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 6.5-2011 222775

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State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 8 2011

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FLEANOR

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick G. Barr, M.D. 5454 Wisconsin Ave., #1300, Chevy Chase, Md. 20854

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sharon Kay Banzhoff Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 XX Hours Min May 18, 1945 Vîrginia **Director** 217-42-9205 66 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and if if item 27 is marked outher than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Washington Williamsport 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 Oak Tree Lane 21795 Apt. E USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married XX Married þ 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2√X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Office Worker State Govt. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis Allen Barbour, Sr. Theresa Virginia Twigg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Oak Tree Lane Thomas E. Banzhoff - Husband Apt. E Williamsport, MD 21795 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Dopation 5 Other (Specify)-06-14-2011 Greenlawn Mem. Park |Williamsport,Maryland 21. Signature of Fundral Service 22. Name and Address of FacilityOsborne Funeral Home, P.A. Þ 6 425 S.Conococheague St. Williamsport,MD 21795 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ REPIRATORY PAILUR ALUTE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HYPOXIC ENLEPHALOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine CARDIAC ARRIG7 Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 1 Yes 2 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate performe Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical B B 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မ 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1. Natural 5 Pending injury I Director: A 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 10/11 MOHAMMED A212 D66892 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DW-U 11116 Medical Campus Rd. Mohammed Aziz M.D. Hagerstown, MD 21742 31. Date filed (Mont) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 5:33 Peggy Virginia Bullard 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Hagerstown Washington If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 XX Nov. 1,1934 Months Days Hours Min. Virg<u>inia</u> Director 220-34-0052 76 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🛛 Yes 2 🗌 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 21740 314 Jonathan Street USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Custodian Utility Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be file Department of Health and Mentall Important: If item 27 is marked of any injury or other traumatic eve ပ John H. Crawley Malinda Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Agnes L. Jackson - Friend 205 Belview Ave. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Buriat 2 Cremation 3 C lova from State Riverview Cemetery 06-13-2011 Williamsport, Maryland Donation 5 Other (Spec 22. Name and Address of Facility Osborne Funeral Home, P. A. 21. Sigg ature of Funeral Service 425 S.Conococheague St. WIlliamsport, MD 21795 23a. Part 1. Enter the sase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Inset and Deatl ovaseuler Physician/ disease or condition resulting in death) week Medical Due to lor as a consequence of): Examiner countietty fish conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or ng physician and as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) Day Pregnant at time of death Month Year 1 Yes 2 Unknown signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident 1 Tes Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 A ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29c. License number
i) 44996 29b. Signature and title of certifier Date signed (Month, Day, Year)

State Registrar

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

Hagerstown, MD 21740

1190 Mt. Aetna Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ghazala Qadir M.D.

31. Date filed (Month,

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oseph Vincent	Boz	1-For State AMENDED per fh item #10@ertificate			g. No. 2011 2007						
Physici Medical Exam		Decedent's Name (First, Middle,Last)		2. Date of Death Month June 1, 20	Day Year 05.00 h						
		Facility Name (if not institution, give street and number) 25129 Wymont Park Road	4b. City, Town, or Location of Deat Worton		4c. County of Death Kent						
Funeral Director			If Under 1 Year If Under 24Hr Months Days Hours Mir		h (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Penna						
' any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits						
Maryland 28a-f show d at ooce.	tor	MD Kent Worton 10e. Street and Number	Lor 7: 0	Lia	1 X Yes 2 No						
i with the Maryland ms 23a or 28a-f sho be ootified at ooce.	Director	25129 Wymont Park Road	10f. Zip Code 21678	10	ng. Citizen of What Country? USA						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-7 she injury or other traumatic evect, the Medical Examiner must be optified at once	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 13. Widowed 4 Divorced If Yes, Give Year 1 Page 19: 10. The State Year 11.	Nas Decedent of Hispanic Origin? (Sf Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc. White						
1036 rithin 72 hours ene. er thao "natur Medical Exam	Completed I	Elementary/Secondary (0-12) College (1-4 or 5+)	lent's Usual Occupation (Give kind of most of working life. DO NOT use rel		16b. Kind of Business/Industry Religous						
21215-0036 uld be filed within 7 Mental Hygiene. marked other thao	Be										
MD 21 d 2 should lith and Me n 27 is ma	٩		ing Address (Street and Number or 29 Wymont Park Ro								
nore, Nages I and of Health tit If item other tran		20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or A 1 1 Sain	osition (Name of cemetery, other place)	Date 6/7/2011	20c. Location - City or Town, State						
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1	Signatur o Funoral Service Licensee 22		175 S. S	tate St. Dover, DE						
Physician -/Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.									
žxaminer		Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular D Due to (or as a consequence of):	isease		Death						
	卢	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
scuted and transit	Examiner	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):									
o, e be execut ysician and burial - trar	edical	UNPENDED AMENDED									
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	- Σ I	Pregnant at time of death	Fetal death 3 Ectopic pregna	ancy	23d. Date of delivery Month Day Year						
ries that the signed by the detache	2	Part II. Other significant conditions contributing to death but not resulting in the Diabetes Mellitus	underlying cause given in Part I.	23e. Did tob	pacco use contribute to the cause of death? 2 No 3 Probably 4 ✔ Unknown						
Division of Vital Records, tal or Attodiog Physiciae: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should be	Completed			24a. Was ar autops perform 1 ✓ Yes 2	y prior to completion of cause of death?						
/ital /siclao: nis certif director,	å	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26 Place of Death (Check nt 3 DOA Other Nursin		Residence 6 🗸 Other Scene						
ion of \text{teodiog Phyeath.} tor: After the funeral.	ation: To	27. Manner of Death 1 V Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Death (Month, Day, Year)			ow injury occurred						
Division To the Hospital or Atteod within 24 hours after death To the Fuoeral Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or Rural or Town, State)									
Div To the Hospital o within 24 hours at To the Fuoeral D	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investignand manner stated.									
F 3 F 3	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) June 1, 2011						
		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltima		1223							
St Regist		31. Date filed (Month, Day, Year) 2011 32. Registrar's Signature	- Albani								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ? 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2011 June 4. 9:05 P M Elvis Joseph Butler 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Casey House Hospice Center Rockville 8. Date of Birth (Month, Day, You Dec. 17, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Days 1 🖾 M 2 🗆 F Months Hours 71 Dec. DC 579-52-0581 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Siver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 United States 812 Malibu Drive 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Yes, Give 2 No African American 1 ☐ Yes 2 A No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Government Printing Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Butler, Sr. Ruby Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silver Spring, Maryland Ann Butler - Wife 812 Malibu Drive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State June 10. Washington, DC 4 Denation 5 Other (Specify) Mt. Olivet 2011 Signature of Fur eral Seg Liounsee 22. Name and Address of Facility Stewart Funeral Home, 20019 4001 Benning Road NE Washington, DC 🗗 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ischemic Cardiomyopathy resulting in death) Due to (or as a consequence of)

Pnysician/ Medical **Examiner**

Department of Health Important: If item 27 any injury or other tr

Physician/

Examiner

Funeral

Director

iral", or items 23a or 28a-f shov Examiner must be notified at

Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho uny or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Medical

10a. State

Director

Funeral

þ

Completed

Be

2

burial-trar physician use for ate has been signed by page 2 should be detac To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director,

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

Examiner Certificate: To Be Completed by Physician/Medical Medical

29a, Certifie

Geoffrey

29b. Signature and title of certifier

Coleman

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1355 Piccard Drive

Sequentially list conditions. b.										
if any, leading to immediate	Due to (or as a consequence of):									
that initiated events resulting in death) Last	Due to (or as a consequ									
IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregna				23d. Date of de	livery				
in the past 12 months? 1										
Part II. Other significant conditions cont	ributing to death but not res	sulting in the underlying	g cause given in Part I.			the cause of death?				
				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of				
25. Was case referred to medical examiner?			26. Place of Death (Che	eck only one)						
1 Yes 2 No	ospital: 1 lnpatient 2	ER/Outpatient 3	DOA Other: 4 \(\sum \) Nursing I	Home 5 Residence	6 X Other (Spec	_{sify)} Hospice				
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj						
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, facto	ery, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Suite 100

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D37142

Rockville, Maryland

29d. Date signed (Month, Day, Year) June 7, 2011

20850

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-04527 State of Maryland / Department of Health and Mental Hygiene Terry James Bergsten 1. For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1748 hrs June 16, 2011 **Medical Examiner** AMES GSTEN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number **Baltimore County** Catonsville 6 Sparrow Hill Road If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5 Social Security Number 6 Sex **Funeral** oreian Months Days Hours Director 63 Country) MISSOURI 8644 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location H 1-XYes 2 X No ALTIMORE CATONSVILL Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.

unt: If item 27 is marked other than "natural", or items 23a or 28a-1 she Director 10g. Citizen of What Country? 10f. Zip Cod 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 1965-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Yes No 1974 1 Yes 2 No specify: Specify: WHITE If Yes. Give Year 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) 4TONSVILLE Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 ANITOR CENTER 0 18.Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) NELORE Be BERGSTEN 19b. Mailing Address. (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) KESVILLE MO 21784 OHNSON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State 8/2011 SOUTH CANDOLL CREM. WINFIELD, MO Donation 5 Other Specify. 22. Name and Address of Facility | NZIMBWJ FH & MON CO 21. Signature of Funeral Service License SYKESVILLERO ELDERSBURG MO 21784 It is the disease, it complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one case on each line. Approximate Interval **Physician** Between Onset and /Medical Death Cardiac Arrhythmia associated with cardiomegaly Immediate Cause (Final diseese Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence or) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - trans Physician/Medical 🕱 AMENDED Items / 10,19b,23a,27,per me,g917 7-1-11 sm X UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day 1 Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by t I be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been suneral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed Yes 2 No 1 🗸 Yes 26. Place of Death (Check only one) Hospital or Attending Physicisn: 24 hours after death. 25. Was case referred to medical examiner Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other: Scene ER/Outpatient 3 DOA 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 X Natural 1 Yes 2 No Pending the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town State) determined within 24 hours a To the Funeral I Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. June 17, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ling Li, MD 31. Date filed (Month, Ray, Year) Registrar

ORIGINAL

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

29b. Signature and title of certifie

Jack Titus MD. 31. Date filed (Month Day

30. Name and address of person who completed cause of death (Item 23a)

4

istrar's Signature

Energy

Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

arke

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 11, 2011

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death CAMPBELL Physician/ ARTHUR VINCENT III June 6 Day 2011 8:30 AM Medical 4c. County of Death Harford 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Forest Hill Examiner Rock Spring Village 6. Sex 1 **X** M 2 □ F Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Pennsylvania Months 88 Director 072-14-9413 Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits important; If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD. Forest Hill Harford 10e. Street and Number 10g. Citizen of What Country? Funeral 21050 United States l Colgate Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes : Maryland 21215-0036 1 ☐ Yes 2 No Specify: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Specify: 3 🗌 Widowed 4 🗆 Divorced White Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Investor Investments Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vincent Campbell Arthur Jr. Catherine Munhall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22611 2379 Springsbury Rd. Laura C. Maclurin (Dau. Berryville, Virginia Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State June 7, 4 Donation 5 Other (Specify) Carroll Cremation Hampstead, Maryland 2011 21. Signature of Funeral Service Lige 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville. Maryland un 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ongestive Physician disease or condition resulting in death) Medical ZOYRS **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown been signed by the should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 certificate 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, ဂ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director; After is completed filled in by the funera 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2505 Belain Rd. 32. Fegistrar's Signature 31. Date filed (Month. 2 3 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rachel Naomi Crichlow June 2011 2140 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Olney Montgomery Montgomery General Hospita If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country), Wash., DC **Funeral** Days Hours 1 - M 2 - F 215 70 8274 53 Director Nov. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Q Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2009 Treetop Lane #22 20904 US 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify: 12. Was Decedent Ever in U.S. 27 is marked other than "natural", or iter traumatic event, the Medical Examiner 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Black If Yes. Give 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 Is and Mental Hygiene.

7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Counselor Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Allwyn F. Crichlow, Sr. Betty Irene Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sł Department of Health a Important: If item 27 is any injury or other tra Donna Crichlow/sister Ivy Club Lane #1614 Landover, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Chesapeake Crematory 6/14 4 Donation 5 Other (Specify) Beltsville, MD 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licen-2294 Old Washington Rd Waldorf, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) death certificate be executed neumon Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical ena attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death Day Year 5 Cher (specify) 1 ☐ Yes 2 ☐ Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed? Yes 2 No certificate 1 Yes 2 No e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificieted filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted 1 (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geam occurred at the time, date and place, and due to the cause(s) and manner as stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RBO State

Box (

Division of Vital

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

31. Date filed (Month

<u>Padmaja Bandi</u>

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18101 Prince

29d. Date signed (Month, Day, Year)

8/ 2011

D0068026

Philip Dr Olney,MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1434 M 2011 Frank Winston June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 709 Anderson Street Silver Spring Birth Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace State or Foreign Country West Africa Sex 1 X M 2 □ F . Age (In vrs. last birthday 1945 **Funeral** 377-60-3670 65 Sierra Leone Director November Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d Inside City Limits Director 1 X Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò event, the Medical Examiner must be Funeral with 23a 20904 709 Anderson Street Sierra Leone, West Africa items ; 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: **Black** If Yes. Give Specify: "natural", 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Paramedic & (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Fire Department years Emergency Medical Technician and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Regina **England** Frank Michael Cosia Daisy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Zaneta Elsweeta Cosia (daughter) 18905 Treebranch Terrace; Germantown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 June It ,201 permit. Page 1 Department of Important: If it any injury or o ō X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland National Memorial Park Landover, Maryland Sonature of Juneral Service Licen Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) m Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ause (Disease or ninjury that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician Physician/Medical that the death certificate be P.O. Box 68760 the nding p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Pregnant at time of death 5 Other (specify) 2 No hed a Unknown g Unknown ed by t detach signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 Jas autopsy perform death? certificate 2 N 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical **Division of Vital** director, 26. Place of Death (Check only one) Be examiner? 1 █ Yes _ 2 ☐ No Other: 4 \square Nursing Home 5 \blacksquare Residence 6 \square Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work? 1 Tes 2 No after death Director: / d in by the f Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide within 24 hours after

To the Funeral Dire

completed filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) 00428 2011 June V MO DUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira Brecher, M.D.;524 Hawkesbury Lane; Silver Spring, Maryland 20904 32. Registra s Sign State Registrar

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		_	For State State Registrar	or iviaryiariu		tificate of D			, No. 2011	20084		
	_		Decedent's Name (First, Middle, Last)				T	2. Date of Death		3. Time of Death		
	Physicia Medic		Evan H. Davis Jr.					June 4	, 2011 Year	5:30p ^M		
	Examin		4a. Facility Name (if not institution, give street and nu			1	Location of Death		4c. County of Death			
			Citizens Care and Rehat	7. Age (In yrs. last	hirthday	F1	ederick	8. Date of Birth	Freder	'1CK place (State or Foreign		
	Funeral Director		5. Social Security Number 204-12-4177 Usual Residence of Decedent	85	Yrs.	Months Days		July 12,	1925 Peni	nsylvania		
	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marke other than "natural", or items 25a or 28a-f show maric event, the Medical Examiner must be notified at	or	10a. State 10b. County	10c. City,	Town or Lo	cation			10d. Inside City Li			
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036	s afte ral", c Exan	q pa	If Yes, G	ive Dates. 1943–4		☐ Yes 2 🔀 No	Specify:		Specify: W	nite		
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at	Completed by	15. Decedent's Education (Specify only highest grade complete		16a. Deced	lent's Usual Occup	ation during most of working	ng 16	6b. Kind of Business Ir	ndustry		
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2	filed wit al Hygie d other went, th	(D)	17, Father's Name (First, Middle, Last)		<u> </u>	Regional	Manager 18. Mother's Name	(First, Middle, Ma	Pharmaceu	ticals		
au	be file ental ked c	To 1	Evan H. Davis Sr.				Mary Kus					
Maryland	2 should be th and Ment 27 is marke traumatic e	- 3	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street			ity or Town, State, Zip	Code)		
	id 2 sh salth a n 27 is er tra	Î	Mary O'Neill / Wife		2501	Coach Ho	use Way #:	2A,Frede	rick,Maryl	and 21702		
ore	of Heal		20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation 3 ☐ Removal fro	m State cer	netery, crer	sition (Name of natory or other plac	ce)		20c. Location - City or Town, State			
Baltimore,	t. Pag tment tant: jury c		4 ☐ Donation 5 ☐ Other (Specify)	Stau			y Inc.6/8		Frederick,			
Ba	permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr	(J	21. Signature uneral Service Licensee	mus	Ş	Name and Address auffer F	uneral Hou	mes P. A	erick,Mary	land 21702		
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and !	Ph_sician/		Immediate Cause (Final	enco scler	20515	COROA	JARY ARC	teny 1) ISEASE	Interval Between Onset and Death		
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Box 68760	tificate ng ph	Physician/Medic	IF FEMALE:	Control 1								
9 x	th cer ttendi or use	ian/	23b. Was decedent pregnant 23c. If yes, o	utcome of pregnance e Birth 2 D Fetal	death 3 L		су		23d. Date of deli	very Day Year		
Bo	the at	ysic	1 Yes 2 No 4 Pr 9 Unknown 9 Un	egnant at time of de known	ath 5 L	Other (specify) _						
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			30 Name and address of person who completed can be seen and address of person who completed can be seen as the seen and address of person who completed can be seen as the see	use of death (Item 2	23a) (Type,	Print)	- Fo.	Destru	Hn 71	701		
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	Sta	te :	31. Date filed (Month, Day, Year) 0 8 20 1 1 32	Registrar's Signatu	re A	boares						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2011 Physician/ Eaton June Henry 4 1:09 P. M Medical 4b. City, Town, or Location of Death
Thurmont 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 11050 Powell Road Frederick Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** Months Days Hours Septh 12 Year)1925 MaryTand 1 □**X**M 2 □ F 220-18-1186 85 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if field 71 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State **Funeral Director** 1 Yes 2 No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11050 Powell Road 21788 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give W Year or Dates. Completed by 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 ★ Widowed 4 □ Divorced WW II 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Government Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samue1 Eaton Grace Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Eaton/Son 11109 Luttrell Lane, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 1 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/8/2011 Olivet Cemetery_ Frederick, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home, PA Frederick, MD 21702 Opossumtown Pike or complications that caused the death. Do not enter the mode of dying, such as cardiac a respiratory arrest 23a. Part 1. Enter the disease shock, or heart failure. Li st only one cause on each line Onset and Death Immediate Cause (Final Physician/ un disease or condition resulting in death) Medical Due to (or as a conseque Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last ysician a e burial-t Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 phy. attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this cleted filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

6+IVA State

within 2 To the

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

William 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harper,

MD

180 Thomas

32. Regist ar's Signature

Registrar

1 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Johnson Dr. suite 101. Frederick. MD 21702

29d. Date signed (Month, Day, Year) 7/11

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** PM Ellis Violet Mae 2011 TULO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland Lions Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year)
May 16, 1927 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours 1□M 2□.F Months 218-24-8222 Director 84 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Examinar Instal to notified an any Injury or other traumatic event, the Marical Examinar Instal to notified an angeles. 1 □Yes 2 □ No MD Cumberland Allegany Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21502 USA 901 Seton Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XIo
If Yes, Give
Year or Dates: Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify Specify: þ 3 □ KWidowed 4 □ Divorced white Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home 12 homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nancy Senn Felix Baldwin ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MN 56501 1537 East Shore Drive Clara Lefebvre daughter Detroit Lake 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 6/18/2011 MD Restlawn Memorial Gardens LaVale 4 □ Donation 5 □ Othe (Specify) 22. Name and Address of Eacility
Scarpelli Funeral Home, PA 21. Signature of Funeral 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between onset and Death 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine To the Hospital or Attending Physlclan: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 □ Yes 2 □ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Jursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending 1 ☐Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director: completely filled in by the f 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00054004 down 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MD 1221 National Highway, Lavale, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:05 A M J**UNE** 03, [□]2011 GEORGE N. GREENHAWK Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CORDOVA TALBOT 9801 COUNCELL ROAD 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 1 🕅 M 2 🗆 F Months Days Hours Min JUNE 01, 1939 Director 217-36-0845 72 EASTON, MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MDTALBOT CORDOVA 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9801 COUNCELL ROAD 21625 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SALES HARDWARE STORE should be filed with and Mental Hygiem is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LESTER N.T. GREENHAWK ALICE E. ANDREW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau NANCY S. GREENHAWK (WIFE) 9801 COUNCELL ROAD CORDOVA, MD 21625 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Commeters Cremators or Other place)
EASTERN SHORE
VETERANS CEMETERY Date 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🗎 Removal from State 4 Donation 5 Other (Specify) 06-10-2011 HURLOCK, MARYLAND Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 10 H OL R. MERCERON 200 SOUTH HARRISON ST. EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Carcinoma Metastatic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam that initiated events resulting in death) Last Due to (or as a consequence of): physician als the burial-t Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performe death? 1 Yes 2 No I ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29c. License number

TUS 10+VA

P.O.

of Vital

Division

Registrar

31. Date filed (Month, Day,

30. Name and address of pe

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

MA

DHMH 17 Rev 7/2009

MI

Esstan.

2/601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #1 - State FH, TCHD, pha 6/8/11 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1110 AM Katherine Bunch Ginder une 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Talbot at Hospital Memorial Easton 212-22-1046 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 👿 F Months Days Hours Min 06-29-1926 Baltimore,MD 84 Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland must be notified at Director 1 Yes 2 X No MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 700 Port Street Unit 510 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 þ 1 Never Married 2 X Married Yes 2 X No within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home other traumatic event, Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 2 Page 1 and 2 should be 1 George Bunch Katherine Dowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i William M. Ginder (Husband) 700 Port Street Unit 510 Easton, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Cremation
Center 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 06-06-2011 4 Donation 5 Other (Specify) Chester, MD 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison St. Easton, MD 21601 ERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Co disease or condition resulting in death) acu -6 Medical Examiner Securifically list one things Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician tached for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Dav Pregnant at time of death signed by the a ld be detached for Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital 2 No Other: 2 1 ☐ Inpatient 2 FR/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death nours after death.

neral Director: After the filled in by the funeral 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide М 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital within 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed IMonth, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ex

DHMH 17 Rev 7/2009

State Registrar Robert B. Sanchez,

31. Date filed (Month, Day, Year)

32. Registrar's Signature

508 Idlewild Avenue, Suite 5, Easton, MD

21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year Constance Glas J 4:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Anne Arundel Edgewater 2212 Shore Drive 8. Date of Birth Oct 25, 1951 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 1 □ M 2 🖾 F Days Months Hours 59 Maryland **Director** 579-70-0338 Usual Residence of Decedent 10a. State 10h County 10d. Inside City Limits 10c. City, Town or Location Funeral Director be notified 28a-f s 1 Yes 2 No Edgewater Maryland Anne Arundel ō 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a must be United States 2212 Shore Drive 21037 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: African American "natural", 3 Widowed 4 Divorced If Yes, Give Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) the Government Postal Worker 12th ulth and Mental Hygie 27 is marked other r traumatic event, th other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Dorothy E. White Joseph K. Jefferson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2212 Shore Drive Edgewater, Maryland Health tem 27 William C. Glass - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Landover, Maryland Harmony 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home. The 1 4001 Benning Road NE Washington, DC 22 P 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Multiple Myeloma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir the attending physician and ned for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Year Dav Yes 1 ☐ Yes 2 ☑ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has 1 Tes 2 No 2 3 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of e Hospital or Attending P 124 hours after death. e Funeral Director: After t Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 2 🔲 Accident Investigation 1 ☐ Yes 2 ☐ No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check 29b. Signature and title of certifier

MS Ky up which MO 29c. License number D0057465

State Registrar

P.0.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. RajapaKSe, M.D

2835 Smith N

5-203 Baldmure, MD. 21209

Day 2011 05 -31 ELEANOR RINALDI HALPIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner EASTON WILLIAM HILL MANOR If Under 1 Year 8. Date of Birth (Month, Day, Year) 01-05-1919 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 92 Director 578-16-4682 Usual Residence of Decedent 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f show D-partment of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Evantual or ust be notified at order. Directo EASTON MD TALBOT 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code UNITED STATES 21601 301 SOUTH HARRISON STREET Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 X No 1 □Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 TNo Specify: ģ 3 N Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) REAL ESTATE SALES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY MUZZOCHI MICHAEL RINALDI ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 SOUTH HARRISON STREET, EASTON, MD 21601 KATHERINE BAYH (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery | 06-07-2011 WASHINGTON, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, Address FENDEIN & NEWNAM FUNERAL HOME, P.A. 301 SOUTH HARRISON ST. EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CRITICAL ARTIC STENDSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of)

1. Decedent's Name (First, Middle, Last)

To the Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Physician

Examiner Physician/Medical Completed by Be Certification: To Medical

DHMH 17 Rev 1/2001

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 ☐ Ctopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year				
	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1				
25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)				
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 □ Yes 2 □ No	Describe how injury occurred				
3 Suicide 6 Could not be 4 Homicide determined	- Jatormina I Zoe, Flace of Injuly - At Hoffle, Iaith, Street, Iactory, office I Zoi, Loi					
29a. Certifier Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my knowledge, death occurred at the time, date and place, and niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

4c. County of Death

TALBOT

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

MONTHS

1K Yes 2 □ No

WASHINGTON, DC

14. Race - American Indian,

Specify: WHITE

29d. Date signed (Month, Day, Year)

6-2-2011

12:45 PM

address of person who completed cause of death (Item 23a) (Type, Print)

AUE FEDERALS BURGIAD 2163Z MD 321 BLOOMINGOALL 31. Date filed (Month, Day,

29c. License number

P0023

State

Registrar

ATTENDING MIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 06nth Margaret Elizabeth Hyser oÎ 2011 5:39 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carroll Westminster Carroll Hospice Dove House Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country)
 MD 8. Date of Birth **Funeral** 1 M 2X F Days **Director** 84 0872471926 220-16-2759 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Westminster Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 354 Ridge Road 21157 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married ☐ Yes 2X☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Nidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) . Page 1 and 2 should be filed within 72 tment of Health and Mental Hygiene tant; If item 27 is marked other than 'iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Black and Decker Machine Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Portia Kirsukoff Norman Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alvia Ray Hyser, husband 354 Ridge Road, Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Evergreen Mem. Gard. 06/07/2011 4 Donation 5 Other (Specify) Finksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel ~6-6 21157 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) equence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events the attending physician and hed for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Coulte 1 Yes 2 Ato 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy MAL DUTRITIO performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Certificate: To NOAMENT 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specific To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No HOSPICE 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WJL 10 Center Street WESTHIWSE , MD21157

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Apples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 3:24 PM 2011 10, Samuel F. Hall, Sr. June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Sparks 16600 Cedar Grove Road Birthplace (State or Foreign Country) If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 ☑ M 2 🗆 F 6, 1944 66 Aug. Director 213-42-4270 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State show is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Evan increust be notified at 1 ☐ Yes 2 No Director MD Baltimore Sparks 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 16600 Cedar Grove Road 21152 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Manager Paper 18. Mother's Name (First, Middle, Maiden Surname) other traumatic event, 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental ... 1 and 2 should be of Health and N Worley F. Hall Hazel Sheetz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Molly R. Hall/Wife 16600 Cedar Grove Rd., Sparks, MD 21152 Department of Heal Important: if item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cremation Direct
Service 20c. Location - City or Town, State June 14 20a. Method of Disposition Pages 1 1 ☐ Burial 2 🔀 Cremation 3 🛣 Removal from State York, PA 2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JJ Hartenstein Mortuary, Inc. 21. Signature of Juneral Service Censes PA 17349 24 N. Second St., New Freedom, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final minites **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Esquertially flet echilic s, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner s been signed by the attending physician and should be detached for use as the burial-transi resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>8</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be irector, page 2 st autopsy performed? 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: An completely filled in here. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29d. Date signed (Month, Pay, Year) 29b. Signature and title of certifier State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

IK UNK		State of Maryland / Departme			and	Menta	al Hyg		20 leg. No.	20093		
Physicia edical Exami	an/	Registrar 1. Decedent's Name (First, Middle,Last) Robert Lee HOVERMALE, JR	١.					Date of Deat Month June 14, 2	h Day Year	3. Time of Death 1650 hrs		
		4a. Facility Name (if not institution, give street and number) Route 220 South near Interstate 68	4		. City, Town, or Location of Death Cumberland				4c. County of E Allegany	4		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 1 Number 217-56-0136 1 Number 6. Sex 61	day) Yrs.	If Under Months	_	If Under Hours	Min		1,1950	J. Birthplace (State or oreign Maryland County)		
Maryland r 28a-f show any ed at once.	Director	Usual Residence of Decedent						10	Og. Citizen of What	-		
Baltimore, MD 21215-0036 The strain is and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s ar 28s-f show injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral D	11. Marital Status 1	If Ye	Decedentes, specify	of Hispa Cuban, M	anic Origin Mexican, F		ify Yes or No- can, etc.)	14. Race - A White, e Specify:	American Indian, Black, etc. white		
0036 within 72 hours in the certhan "nature Medical Exami	Completed b	Elementary/Secondary (0-12) College (1-4 or 5+) 12 2 ma	s Usual Od st of worki	ng life. D and l	o NOT us	se retired)		anufacturer			
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. In 27 is marked other than unatic event, the Medica	o Be Co	17. Father's Name (First, Middle, Last) Robert Lee Hovermale, Sr. 19a. Informant's Name/Relationship (Type, Print)	Mailing	Address			Mer	ilyn A	deline Ca	iden Surname) eline Cain er, City or Town, State, Zip Code)		
and 2 shou ealth and N tem 27 is n traumatic	ř	Elizabeth Cox - daughter 30 20a. Method of Disposition 20b. Place of	43 V Disposi	iewpo	int	Way,	Way			ylvania 17268		
Baltimore, permit. Pages I an Department of Hee Important: If itel injury or rither tr		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	town	erplace) 1 Crei			June		Hagersto Funeral	wn, Maryland		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not	41	5 Eas	t Wi	Llson	B1v	d., Ha	gerstown	Maryalnd 217 Approximate Interval		
/Medical :xaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a No Identifiable To Due to (or as a consequence of):	xic	ologi	cor	Anat	omic	Cause	Of Death	Between Onset and Death		
	Examiner	Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
be executed ician and inial - transit	dical Ex	d. ☐ AMENDED 23a, 27, 28a-f, per me, g916 6-24-11 sm										
X 68760 tth certificate I uttending phys or use as the bu	š	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 4 Pregnant at time of death 5		al death er (Specif		Ectopic p	pregnanc	<i>y</i>	23d. Date of de Month	livery Day Year		
by the	至	Part II. Other significant conditions contributing to death but not resulting	in the ur	nderlying c	ause giv	en in Part	1.	1 Yes	2 No 3	te to the cause of death? Probably 4 Unknown		
of Vital Records, P.C. ing Physician: The law requires that After this certificate has been signed timeral director, page 2 should be deta	Completed			200	Diego	f Dooth /C	hook onl	24a. Was a autop: perfor	sy prio m <u>ed</u> ? dea	re autopsy findings available or to completion of cause of the completion of cause of the completion o		
1 of Vital Recing Physician: The l	To Be	1 V Yes 2 No	tpatient	3 🗌 DO	A O		Nursing I	lome 5	Residence 6			
		1 Natural 5 Pending (Month, Day,Year) 2 Accident Investigation fd 6-14-11 fd	4:5	pm	1 Ye	at Work?	v∘ U	nknown				
Divis ospital nr A hours after nneral Dire y filled in b	28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 4 Homicide 4 Homicide 4 Specify) 5 Found in wooded area 28f. Location (Street and Number of Town, State) Rt 220 1 Interstate 68							tate) Rt 220 ate 68 C	South near umberland,Md.			
To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or in and manner stated.	tn occum vestigati	on, in my o	pinion, c	death occu	e, and du urred at th	ne time, date a	and place, and due	to the cause(s) (Month, Day, Year)		
	~	D-70L-			D.C.M		16		June 15, 201			
		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner	900	W. Balti	more S	Street, E	3altimo	re, MD 21	223			
St Regis		31. Date filed (Month, Day, Year) 32. Registrar's Signature	,									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

4:10

9. Birthplace (State or Foreign

Country) Maryland

White

Osborne

Approximate Interval Between Onset and Death

Dav

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

10d. Inside City Limits

1 Yes 2 No

20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **CRNP** 2300 DULANEY VALLEY RD. JACKIE JONES, 31. Date filed (Month, Day, Year,

State Registrar

Medical

29a. Certifier

29b. Signature and title

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

2 Image: A certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

State Registrar 31. Date filed (Month, Day, Year) 321 BLOOMINGDALE AUE FEDERALS BURG. MI

ATTSNOING MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

RS 5

29c. License number

4805309A

29d. Date signed (Month, Day, Year)

JUNE 2, 2011 12:45 p.m. Frank Lopreato

			Plea	ase Type or Pri		Indelible Inlipartment of F						
			For State Registrar	eg. No. 0	20096							
	Physicia		1. Decedent's Name (First, Middle					2. Date of Death Month	h Dav Year	3. Time of Death		
Н	Medic	al	Frank J. 4a. Facility Name (if not institution	Lopreato		4b City Town of	r Location of Death	June 2,	ane 2, 2011 12:45p M			
	Examin	er	Stella Maris H			Timor			Baltin	I		
	Funeral Director		5. Social Security Number 219–22–3559	6. Sex 7. Aga 1 🛣 M 2 🗆 F	If Under 24 Hrs. Hours Min.	8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country) 10/25/1927 MD						
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County PA YC	ork	10c. City, Town or Glen R	Location OCK				10d. Inside City Limits 1 ☐ Yes 2★☐ No		
	with the M 23a or 28 ist be not		10e. Street and Number 4169 Huff	manville F	l ≀oad	10f. Zip Code 17	327	1	10g. Citizen of What Country?			
936	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mertal Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner.	d by Funeral	11. Marital Status 1 ☐ Never Married 2 🔀 Mar 3 ☐ Widowed 4 ☐ Divorced	If Man Cline	No	lispanic Origin? (Spo an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W				
21215-0036	2 hours "natur edical I	Completed	15. Decede	ent's Education est grade completed)	16a. De	cedent's Usual Occup ve kind of work done	during most of work	ing	16b. Kind of Business	ness Industry		
2121	vithin 7 iene. er than the Me		Elementary/Seconday (0-12)	College (1-4 or 5)+)	. DO NOT use retired) rehouse			Howard	Johnson's		
Maryland 2	should be filed within 7 h and Mental Hygiene. 7 is marked other than traumatic event, the M	To Be	17. Father's Name (First, Middle,	Last) Lopreato	•			e (First, Middle, M ine Mat	Maiden Surname) rangolo			
	and 2 should Health and M tem 27 is ma		19a. Informant's Name/Relations Margaret Lop		fe 19b. Ma 416	ailing Address (Street 9 Huffma	and Number or Run nville	al Route Number Rd., G1	City or Town, State, 2 en Rock,	PA 17327		
Baltimore,	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 ■ Surial 2 □ Cremation 4 □ Donation 5 □ Other (3 ☐ Removal from State	camatany c	sposition (Name of rematory or other place y Valley	MG 6/7	/2011	20c. Location - City o	, MD		
Balti	permit. Page 1 al Department of H Important: If itel any injury or ott	- 1	21. Signature of Funeral Service	Licensee MOO7 Lemme	41	22. Name and Addre	ess of Facility E	line Fu	neral Hostead, MD	ome 0 21074		
٠ ا	Physician/		23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each line	d the death. Do not e e. CANCER	enter the mode of dyir	ng, such as cardi <i>a</i> c	or respiratory <i>a</i> rre	st,	Approximate Interval Between Onset and Death		
	Medical Examiner		resulting in death)	a. Due to (or as								
	ted	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
0	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequence of):							
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Box 6	e death certificate be the attending physici hed for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a g Unknown	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify) _	cy		23d. Date of c	23d. Date of delivery Month Day Year		
ls, P.O.	requires that the de been signed by the should be detached	ed by Ph	Part II. Other significant conditi	ions contributing to death b	out not resulting in th	ne underlying cause g	iven in Part I.		,	to the cause of death? Probably 4 Unknown		
Division of Vital Records,	hysician: The law req his certificate has bee I director, page 2 shou	Completed by		···				24a. Was ar autops perforr 1 \(\sum \) Yes	sy prior to med? prior to death?	nutopsy findings available completion of cause of		
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ivisio	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Certificate:	3 Suicide 6 Could	28e. Place of Inj	ury - At home, farm, c. (Specify)	street, factory, office	1 ☐ Yes 2 ☐ No office 28f. Location (Street and Number or Rural Route Number City or Town, State)					
OO TO TO THE PROPERTY OF THE P									e cause(s) and manner stated.			
	WITL	2	29b. Signature and title of certific		P	29c. Licens			29d. Date signed Mor			
	12+1VA		30. Name and address of person	CD1D 2200	de <i>a</i> th (Item 23a) (Typ		TIMONTI	M. MD 21	093			
	Sta Registr		31. Date filed (Month, Day, Year)	6 2011 32. Registr	ar's Signature	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month n a 20°11 1:15 P M John Bruce Moores Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Hours Country) MD 1 ▼ M 2 □ F 05/18/1935 Director 215-32-8292 76 Usual Residence of Deceden 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗶 No Finksburg MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21048 USA 2716 Appleseed Road death v 12. Was Decedent Ever in U.S Armed Forces? 1 2 Yes 2 No 19 If Yes, Give 10 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 10 þ 1 Never Married 2 X Married 1957-Black, White, etc. within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced 4 Divorced 1959 Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert G. Moores, Sr. Lillian Armacost 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Moores, wife 2716 Appleseed Road, Finksburg, MD permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Kriders Cemetery Westminster, MD 4 Donation 5 Other (Specify) 06/06/2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home of no 21157 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a c Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a con-Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Day Month Year 2 🗌 No been signed by the s 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. e Funeral Director: After this certificate has autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate; 28h Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 033541 MZr # 114, Ellersburg M 1380 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2011 Month Year **Physician** June 10, 6:30 P M Frances Virginia McNamee /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hagerstown
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Washington Golden Living Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** 1 □ M 2**X**) F Months 89 16, 1921 Maryland Director 216-14-6151 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Hagerstown Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21740 750 Dual Highway by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lilly May Socks Roy C. Swartz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16407 Kaiser Ct., Hagerstown, MD 21740 John S. McNamee / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Lawn Memorial Park 06/14/2011 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac St., Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death adeno carcinoma Immediate Cause (Final ,Physician 5 montes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 → No 24a. Was an autopsy page 2 2000 2 No 1□ Yes the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 20 No 1 | Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours af To the Funeral D Learning Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 368 nill Street Hagestam MD 32. Regi 31. Date filed (Month, Da State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2:58 PM MacDouga1 2011 Danie1 06 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Caroline Denton Caroline Nursing Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country Pennsylvania (Month, Day, Year) Hours 1 🛛 M 2 🗆 F Days 1947 Yrs. 176-52-6173 63 Director Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 Y Yes 2 □ No Maryland Caroline Denton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21629 810 Daffin Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Not employed None Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ John MacDougal Dorothy Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 S. Third St., PO Box 400, Denton, Maryland 21629 Dsvaldina G. Daly/Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20c. Location - City or Town, State 6/9/2011 Dover, Delaware 4 Denation 5 Other (Specify) Capitol Crematory 22. Name and Address of Facility Moore Funeral Home, P.A. 21. Signature of Funeral Service Licer 12 South Second Street, Denton, Maryalnd 23a. Part 1. Effer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ reek 5 disease or condition Medical resulting in death) Due to (or a Examiner Sequentially list conditions, Examiner Due to for as a nonsequence of, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician at the burlal-t Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Į, Month Day Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2. No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Mannar of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending Natural ithin 24 hours after death.

the Funeral Director; As ampleted filled in by the fu 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Items 4b per fh/dvr,g916,06/23/2011dhb
Registrar

State of Maryland / Department of Health and Mental Hygiene
Per fh/dvr,g916,06/23/2011dhb
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12ª 201 Physician/ Delores Lee Moreland June 12;20 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Allegany Devlin Manor Healt Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 □ M 2 🗓 F Months Days Hours Min 234-42-9632 82 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Allegany Rawlings 1 Yes 2 X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21557 **USA** 23a 18612 McMullen Highway or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 1 and 2 should be fill be fill be fill be fill be fill be fitten 27 is marked 2 Ira M. Lipscomb Lena Reis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 160 Curbs Road, Red Lion, PA 17356 Clayton Moreland/son or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial 6/14/2011 Cumberland, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Name and Address of Facility Markwood Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line terval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and trar Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 2 No signed by the a d be detached f Yes 1 ☐ Yes 2 ₩ g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? 1 ☐ Yes 2 ☐ No Yes 2 IN director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 HNo ည 1 Inpatient 2 ER/Outpatient 3 E 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 D0017565 ene 13, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LiVile NITI Huy カロ State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** June Velma McConnell 2011 11:45P Lee /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Federalsburg Caroline 518 Liberty Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) Mar. 10, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year. Days 83 Yrs. 213-22-9550 Maryland 1928 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examinat must be notified at Caroline 1 ☐ Yes 2X No MD Director Federalsburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21632 United States 518 Liberty Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or iter 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐Yes 2X No White Specify: ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker (Graduate) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nora E. Newcomb Floyd Rufus Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any Injury or other trau once. 510 Liberty Road, Federalsburg, MD 21632 James H. McConnell/ 20b. Place of Disposition (Name of cemetery, crematory or other place)

Fastern Sh. Veterans Cem. 06/17/11 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DNTH Physician LUNG disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician the burial Physician/Medical attending p for use as IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) Ö ed by the detached signed by to be detach ٥. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ ROSLLEROTIC CARDIOVASCULAR 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed? certificate 1 ☐ Yes 2 No or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Division (Month, Day, Year) 1 Naturai 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) SOMINODALE AUE FEDERALSBURG, MD 31. Date filed (Month, Day, Year) State

ORIGINAL

R o

Registrar
DHMH 17 Rev 1/2001

JUN 0 7

State Registrar 32 Registrar's Signature

Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Jack Titus MD. Dep

Please Type or Print in Black Indelible Ink. Ensure, All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day JUNE Physician/ 13 2011 11:00A NANCY LORRAINE MUSGROVE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 7. Age (In yrs. last birthday) 79 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 1 🗆 M 2 🟋 F March Day ^{Year}1932 217-28-9118 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show am point or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d Inside City Limits 10a. State Director Frederick 1 X Yes 2 □ No Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral U.S.A. 21703 1312 David Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Publishing Remittance Analyst Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gladys Rinker ည Harry Appel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1312 David Lane, Frederick, Maryland 21703 H. Frank Musgrove, husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Smithsburg Crematory June 19, 2011 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Smithsburg, MD 4 Donation 5 Other (Specify) Signature of Funeral Servic Lic 2Keeney^dand Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine il arry, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year s been signed by the s should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No Yes 2 No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 2 🗶 No 1 Yes မ Papatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No Natural 5 Pending in 24 hours after death, in Funeral Director: At oldered filled in by the fu Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventionable in a stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Centifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

complet only one) 29b. Signature and title of Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 2340 M Physician/ Lou Jean Kittylee NYE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Hagerstown Meritus Medical Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex Social Security Number Funeral 1 □ M 2 🕅 F Months Hours Country)
Maryland 81 Director 216-22-9180 May Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b County 10c City Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director must be notified 1 ☐ Yes 2 X No Hagerstown Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 'n 23a USA 21740 17423 Amber Drive items 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No 14. Race - American Indian, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc þ ō 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced other than "naturent, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Her own home 0 Homemaker 11 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked o ပ Alice Sellers David Rowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 10725 Pickett Court, Williamsport, Md. 21795 Kittylee Harbaugh - Daughter 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 6/22/2011 Hagerstown, Maryland Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice Minnich Funeral Home 22. Name and Address of Facility 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ORONARY Medical Examiner Sequentially list conditions, Examiner or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last attending physician a for use as the burial: Be Completed by Physician/Medical 15845C Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Month Dav Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has le 2 performed this certificate Yes 2 X 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No ပ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 24 hours after death. Funeral Director: After Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death Suite 34 W-5 State Registrar

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		-	For State Registrar	State of IVI	aryiand	-	rtment of r tificate of	lealth and N Death		Reg. No.	20105
	Physici		1. Decedent's Name (First, Middle, La						2. Date of De Month	Day Yes	3. Time of Death
46	/Medio Examin		Kathleen Ann OYLER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea							4c. County of D	
-				etheran V		-	Hagers	tour		Washi	0
	Funeral Director		5. Social Security Number 6.	- N7 -	je (In yrs. las .00	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March	av. Year)	Birthplace (State or Foreign Country) ennsylvania
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
	Maryl-f sho	호	Maryland Washin	aton		На	gerstown				1X Yes 2 □ No
	r 28a	irec	10e. Street and Number	gcon		IIG	10f. Zip Code			10g. Citizen of What	Country?
	th wit	ral	65 Devonshire Ro	ad				1740		USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination in the rediffed anone.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🎖 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 14 If Yes, Give Year or Dates:			Nas Decedent of H fYes, specify Cub I □Yes 2XINo	Hispanic Origin? (S an, Mexican, Puerto Specify:	pecify Yes or No p Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. White
9	2 hou	ted	15. Decedent's E	ducation		16a. Deced	lent's Usual Occup	pation	ula -	16b. Kind of Busine	ss/Industry
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anc	i be fi ental H ed ot	Be o	Edward Keefer Mc							Sanders	
Maryland	d 2 shoult th and Me 7 is mark traumatle	은	19a. Informant's Name/Relationship	Type. Print) Great Gre	at			and Number or Ru	ral Route Numb	per, City or Town, State	
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Baltimore,	Pages ent of nt: If i		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				. Cemeter	1	/2011	Hagerstow	n, Maryland
alti	mit. I partm portal / inju		21. Signature of Funeral Service Lice		TROBE	22	. Name and Addre	ess of Facility	Minnich	Funeral H	Iome
8	De la la la la la la la la la la la la la		Vio and ISK	el-		4	15 E. Wi	lson Blvd	. Hager	stown, Mar	yland 21740
	Physician		23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each li	the death. ne.	Do not ent	er the mode of dyi		or respiratory a	arrest,	Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (11)s	a conseque	nce of):	- p-3-cp				
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	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseque	rice or).					
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O. Box	death e atten d for u	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1							23d. Date of Month	delivery Day Year
σ.	res that the de signed by the a be detached t	Ph)	Part II. Other significant conditions	contributing to death b	out not resulti	ng in the ur	nderlying cause giv	ven in Part I.	23e. Did 1	tobacco use contribut	e to the cause of death?
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Ž	Physician: r this certific ral director, i	o Be	examiner? 1 ☐ Yes 2 ☐No	Hospital: 1 ☐ Inpati	ent 2 🗆 El	R/Outpatier	nt 3 □ DOA Oth			idence 6 Other (Specify)
n 0	ding Physician: The In. After this certificate har funeral director, page	J:uo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju	ury 2 ay, Year) 2	8b. Time of Injury	Wo	iry at rk?		how injury occurred	
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Division	or At after d Direct in by	Certification: To	4 Homicide determined	28e. Place of Inj	ury - At hom c. <i>(Specify)</i>	e, farm, str	eet, factory, office			wn, State)	r Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 12 Certifying P	nysician: To the best miner: On the basis of and manner st	of examination	edge, deatl on and/or in	n occurred at the t vestigation, in my	ime, date and place opinion, death occu	e, and due to the irred at the time,	e cause(s) and manne , date and place, and	er as stated. due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	gna.	1_		29c. Licen	8765		29d. Date signed (M	,
M	- 3		30. Name and address of person who	completed cause of	teath (Item 2	23a) (Type,	Print)	esos Huel	- Heu	Esteum	21740
	Sta	te	31. Date filed (Month, Day, Year)	32. Registi	rar's Signatui	re	1 1	, , , , , ,)	·
	Registr	-	JUN 13	2011 Sen	wa,	1. 19	arks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 31 per dvr 2916 6-23-11 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June June ^D2011 Physician/ 6:05 A M 16, Harold F. Ohler Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Grantsville Goodwill Mennonite Home 8. Date of Birth (Month, Day, Ye May 28 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number ^{Year)}1<u>927</u> Funeral 1**X** M 2 □ F 84 196-22-7873 Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10c. City, Town or Location 10a, State Examiner must be notified at Director 1x Yes 2 ☐ No Somerset Somerset 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code items 23a Funeral 15501 USA 126 West Church St. death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No d Mental Hygiene. marked other than "natural", or i þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sawmill Laborer 8 other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mattie Jane Younkin Alexander Ohler and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh.
Department of Health ar
Important: If item 27 is 126 West Church St., Somerset, PA 15501 Helen M. Ohler Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 06/19/2011 4 ☐ Donation 5 ☐ Other (Specify) Old Bethel Cemetery Markleton, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Humbert Funeral Home, PO Box 37, Confluence, PA CC0376 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final NeumoniA Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 21+E=1m Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last and-tran Due to (or as a consequence of) physician a sthe burial-Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year law requires that the death Pregnant at time of death 5 Other (specify) the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Jas page 2 certificate I Yes 2 X N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ြု After this 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Hospital or Attending 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June 16, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robin Bissell 124 Miller St Grantsville. 31. Date filed (Month, Day, Year) State June 18. 2011 Registrar

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		State of Maryland / Department of Health and Mental Hygiene Cortificate of Death										07				
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/an	d be fi dental rrked tic ev	2	Maurice Rober	t Perrygo					Le	eila	Amado	n				
Maryland	2 should be file lith and Mental B 27 is marked or r traumatic eve		19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	er or Rura	l Route Numb	er, City or	Town, State	e, <i>Zip</i> Co	ode)	
	CO TO T		Robert A. Per	rygo / Son	1	10604			ın Av			1				774
Baltimore,			20a. Method of Disposition 1 🛭 Burial 2 🗌 Cremation			Place of Dispo cemetery, crer	natory or o	ne of ther place	e)	Jur	ne 11,		cation - Ci			
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-	Medical Examiner		resulting in death)	a. Due to (or	as a conseq	uence of):			7.7	-	<i>u</i> 19	7 6				
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Box 68760	death certificate be he attending physic ed for use as the bu	Physician/Medica	IF FEMALE:													
9 x	th cer ttendi	ian/	23b. Was decedent pregnant in the past 12 months?		rth 2 - Fet	al death 3			У			2	23d. Date o Month		delivery Day Year	
8	g e g	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 ☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown							***************************************				
P.0	iician: The law requires that the des certificate has been signed by the s rector, page 2 should be detached	by Ph	Part II. Other significant condition	ons contributing to dea	th but not re	sulting in the u	ınderlying (cause give	en in Part	l.	23e. Did	tobacco us	se contribu	ite to the	cause of dea	ath?
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n O	ding F h. After funer	ate	1 ☑ Natural 5 ☐ Pendir	ng (Month,	Day, Year)	injury	M Z	8c. Injury work?			28d. Describe	now injury	occurred			
Sio	Atten	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of		ome, farm, str				\rightarrow	28f. Location		Number o	r Rural F	Route Numbe	r,
	Hospital 24 hours a Funeral C	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To the bes xaminer: On the basis	t of my know	vledge, death on and/or invest	occured at	the time,	date and	place, and	d due to the o	ause(s) and	d manner a	s stated.	e(s) and man	ner stated.
only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manne 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mr.								er as stat	ed.							
29b. Signature and title of certifier 29c. License number D51643 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hiron Shah mo 65 Thomas Thomas 31. Data filed (Month Day Year) 32. Register's Signature.									_							
			30. Name and address of person	who completed cause	of death (Iter	n 23a) (Type, F	Print)		104			-/-	, , , ,			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2011 June Rosalie Ann PENTONEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Year | If Under 24 H 3510 Scarlet Sage Court Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Oct. 18 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Months 1 □ M 2 🗓 F Yrs 1918 Maryland 92 Director 220-10-3277 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10a. State 1 ☐ Yes 2X No Director Hagerstown Maryland Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with USA 21740 Funeral 13510 Scarlet Sage Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Black, White, etc. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No altimore, Maryland 21215-0036 Specify White 3 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Her own home Homemaker 10 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ora Blanche Colbert George William Spence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) it of Health 1211 Potomac Avenue, Hagerstown, Maryland 21742 Karen P. Lewis - daughter other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of Important: If any injury or once. Lovettsville, Va. June 14 2011 Union Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd. Hagerstown, Maryland 21740 halu Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Mibilitation disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Julti maro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) been signed by the should be detached 9 | Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has the autopsy performe 1 ☐ Yes 2 ☐ No 1 □Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Certification: To Be examiner Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier within 24 hor To the Fune completely fi Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kelli Fraus's E-WE Hagers town 5+,101 Conneylvas Wenne State Registrar

DHMH 17 Rev 1/2001

249

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1742 PM Ronald Kiagins 06 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore of Med 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 X M 2 🗆 F Months Hours th, Day, Year) West Virginia 236-46-673 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Maryland Caroline Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14924 Cherry Lane 21660 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Mantal Status Armed Forces? 1 XYes 2 ☐ No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🗓 No Specify: Specify: 3 Widowed 4 Divorced Completed White 1950-53 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 equipment operator steele industry Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Gladys Reese Percy D. Riggins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria J. Riggins/ wife 14924 Cherry Lane; Ridgely, Maryland 21660 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Chesapeake Cremation June 13 2011 4 Donation 5 Other (Specify) Chester, Maryland 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 21. Signature of Funeral Service Licensee Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AnoxIC brain disease or condition Medical resulting in death) Examiner Weeks Preumonia/Respirat Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown CAD, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has blirector, page 2 s performed? Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 🗌 Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA မ After this s after death.

I Director; After this id in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined after within 24 hours aff

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AU4176435K19755 30. Name and address of persop who completed cause of death (Item 23a) (Type, Print) 140112 Zachar N4W94, Baltimore, Greene 27 KON 31. Date filed (Month, Day, Year) State UN 13 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended State Nee, FH, TCHD, pha 6/8/11 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician/ 6 2011 June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Talbot Easton <u>Genesis HealthCare</u> The Pines . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Months Hours Min. (Month, Day, Year) Director Usual Residence of ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location death with the Maryland **Funeral Director** 1 Yes 2 No ton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 713 Dover Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Decedary
Armed Forces?

1 Yes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examinonce. 1 Never Married 2 Married ş 1 Yes 2
If Yes, Give
Year or Dates Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use reţired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 44 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number ,216 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Si nature Funeral Service Licenses Easton, NW21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Immediate Cause (Final Pnysician/ MANIA disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil o (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 month 1 Yes 2 No 3 Ectopic pregnancy Day Month 5 Other (specify) Pregnant at time of death been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2 s autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 □ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending Yes 2 No М Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, death (Item 23a) (Type, Print) *UUTCHMANA* 61 State JUN 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended,#301 - State Registrar MD, TCHD, 6/2/11, rls Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CLARA C. SCHLOTZHAUER 05 201 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TALBOT CORDOVA 11110 THREE BRIDGE BRANCH ROAD Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex Funeral 1 🗆 M 2 🛣 F Days Hours Min 02-05-1923Director 88 MD 220-12-0646 Usual Residence of Deceden 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 X No MT TALBOT CORDOVA 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral UNITED STATES 11110 THREE BRIDGE BRANCH ROAD 21625 Iral", or items 2 Examiner mus 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specity: WHITE "natural", 3 X Widowed 4 ☐ Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) HOMEMAKER OWN HOME is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOSEPH RAYMOND CALLAHAN ALPHONSO ESTELLE GOLT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CORDOVA, MD 21625 MARY ANN SHORTALL DAUGHTER 11885 BLADES RD injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of F Important: If ite any injury or oth cemetery, crematory or other place. XBurial 2 Cremation 3 Removal from State WOODLAWN MEM. PARK 06-06-2011 EASTON, MD 4 Donation 5 Other (Specify) FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST. EASTON, MD 21601 at aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, i each line. 23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause of Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequ resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregr 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 more 4 ☐ Pregnant at time of death 9 ☐ Unknown the 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? here to more following surgery for Completed by 2 ■No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an itenne cancer. has autopsy death? or Attending Physician: The this certificate 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide I Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) 24 hours a Hospital 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signatur 29c. License number ess of person who completed duse of death (Item 23a) (Type, Print) Dr. Curtis Foy Easton, MD 21601 555 Cynwood Drive Curtis 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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onald Schlitzer	Rec	For State		Maryland		artment rtificate			i Menta		Reg. No	20	Bossery' vzty	20114
Physician Medical Examine		Decedent's Name (First, M Ronald Willi	iddle,Last) am Sch	litzer						2. Date of Do Month June 1,	Day	Year		3. Time of Death 0314 hrs
		. Facility Name (if not instit		eet and number)				y, Town, or l	Location of C		4	ic. County o	f Death	
Funeral Director		Social Security Number 220–98–1871	6. Sex			ast birthday		nder 1 Year nths Days		8. Date of Min. 01/0			9. Birth Foreigr Cou	piace (State or Maryland
ow any	108	ual Residence of Deceder a. State 10b. Cou laryland Carr	nty	unty		Town or Lo								10d. Inside City Limits 1 X Yes 2 No
with the Maryland ns 23a or 28a-f show be notified at once.		e. Street and Number 1428 Popes (Zip Code 21074	_		_	tizen of What		-
or ites	11.		Married 1	es, Give Year		.S. 13.	If Yes, spe		Mexican, P	? (Specify Yes or I uerto Rican, etc.)	No-	14. Race White	, etc.	an Indian, Black,
1215-0036 doe filed within 72 hours after femal Hygiene. arked other than "natural", event, the Medical Examiner	ᇎᆜ	5. Decedent's Education (SEIementary/Secondary (0-12	Specify only h	Dates: ighest grade con College (1-4 or		durin		working life.	on (Give kin DO NOT us	d of work done e retired)		Kind of Bus		house
21215-0036 July be filed within 7 Mental Hygiene, marked other than ic event, the Medical	e e	Father's Name (First, Mid William G. S	chlitz			1405-14-	::: A .dd		Linda	J. Zile			Ct-t-	To Oode)
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Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and b Important: If item 27 is n injury or other traumatic	1 4		Specify:	Removal from St	ate '	Place of Discrematory o	rotherpla	∞) Luthei	ran	June 6, 2011	н		ead,	own, State Maryland
Balti permit. Departn Import	21.	21. Signature of Funeral Service Liches M01072 22. Name and Address of Facility Eline Funeral Home 934 South Main Street Hampstead, MD												21074
Physician Medical		23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a, Multiple Injuries											_	Approximate Interval Between Onset and Death
Examiner		condition resulting in deat		to (or as a cons		f):								
ted Insit	Se if a car	equentially list conditions, any, leading to immediate use. Enter Underlying Cal issass or injury that initiats	se c.	to (or as a cons										
executed an and al - transit		ents resulting in death) La	st Due	to (or as a cons	equence o	rr):								
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ox 6876 sath certificat attending ph for use as the	23b	FEMALE: b. Was decedent pregnant past 12 months? Yes 2 No 9	n the 1 Unknown 9	3c. If yes, outcor Live birth Pregnant at Unknown		2	Fetal dea		Ectopic p	egnancy		Month	Da	ay Year
ires that the daising by the detached is	2	rt II. Other significant co	editions cor	ntributing to deat	h but not r	esulting in t	he underly	ing cause g	iven in Part I					ne cause of death?
of Vital Records, ag Physician: The law require the this certificate has been si meral director, page 2 should b	Completed									1 ✓ Yes	is an opsy formed?	pr		opsy findings available ompletion of cause of
Vital ysician:	25. 0	. Was case referred to med examiner? 1 ✓ Yes 2 No	lical	ital: 1 Inpatie	ent 2	ER/Outpat	ient 3		^··	ursing Home 5	Resid	lence 6	Other:	Scene
Attending Ph r death. rector: After ti by the funeral	27	. Manner of Death Natural 5 F	ending	28a. Date of Inju FOUND: Jun 1, 2011	Iry 'ear)	28b. Time FOUND: 0302 hrs			y at Work? es 2 N	28d. Describ Subject pi				and shelf
Yis Per A Direction of the Per A Direction of	3 4	Suicide 6 0	ould not be etermined	28e. Place of Ind			street, facto	ory, office bu	uilding, etc.	28f. Location or Town 400 Bennet	(Street , State) t Cerf D	and Numbe Orive, Wes	r or Run tminste	al Route Number, City
0 - 5 - 5	1 298	a. Certifier 1 Certifyin heck only 2 Medical	xaminer:On	To the best of m the basis of exa d manner stated.	y knowled mination a	ge, death o nd/or invest	ccurred at igation, in	the time, da my opinion,	te and place death occur	, and due to the ca red at the time, da	iuse(s) a te and p	ind manner lace, and du	as state ue to the	d. cause(s)
M27 3	291	b. Signature and title of ce		mariner states.	1		- 1	29c. License		- · · · · · · · · · · · · · · · · · · ·				th, Day, Year)
w 5	30.	. Name and address of per	son who com	oleted cause of c	leath (Item	23a		O.C.N	VI.L.		301	ne 1, 201	1	
	24	Zabiullah Ali, M.D.					/. Baltim	ore Stree	et, Baltim	ore, MD 2122	3			
Stat Registra	~	. Date filed (Month, Day, Ye	6 2011	32. Registra	_		ake	/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 06, 5:17 A M 2011 Archie Lacy Sinclair, Jr. June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Preston 22835 Dover Bridge Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Maryland 69 3, 1942 Director 212-40-9655 Apr. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 20No Director Caroline Preston MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21655 22835 Dover Bridge Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Dayes 2 No. If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black White etc 72 hours after 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 "natural", or White 1 ☐ Yes 2 X No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tree Care Arborist 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) Archie L. Sinclair, Sr. Anna Oneida 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Della Sinclair/Spouse 22835 Dover Bridge Rd., Preston, MD 21655 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hurlock, Maryland 06/13/11 Fastern Sh. Veterans Cen. 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 8 Months Physician emana disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to (or as a consequence of). Examine death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. physician Physician/Medical the as attending IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) 2 No P.O. the detached 9 Unknown 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ HO 3 ☐ Probably 4 ☐ Unknown metastarle Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Sophac autopsy performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After t After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completely fil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Juwood Dr. Gaston MA 21601 M.D ettrey ton 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ J₩M世 13, ^D2011 7:20am Sara Schneider Ann Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Gilcrest Hospice Towson If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday Funeral Pay 1931 Months Days Hours Min 1 □ M 2 🛛 F 577-42-7373 Yrs. Apr Ohio Director 80 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10a, State 10b County 10d. Inside City Limits Examiner must be notified at Director Columbia Maryland Howard 1 Yes 2 X No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 21044 U.S.A. Funeral 6500 Freetown Road items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 9 Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No if Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🛛 No Specify. Specify: "natural" White 3 Widowed 4 X Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) A.T.&T. Communications Customer Educator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be file lith and Mental F 27 is marked o မ Lohnes Sara Harriet DeWitt Manfred George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heath a Important: If item 27 is any injury or other transconce. 1404 Langbrook Place, Rockville, Maryland 20851 Martha Schneider, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory Jun 14,2011 4 Donation 5 Other (Specify) Smithsburg, Maryland ^{22. Name and Address of Basiliv}sford P.A. Funeral Home 106 E Church Street, Frederick, Maryland 21701 21. Signatur of Funeral Service Licenses M00706 106 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ reurs disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last ng physician a as the burial-Physician/Medical Box 68760 IF FEMALE: use a 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death the Unknown g Unknown Division of Vital Records, P.O. cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) xaminer2 1 Yes 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending work 1 🗌 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 100 40635 Bu who completed cause of death (Item 23a) (Type, Print) P 4105 Baltimore MD churles St α 6701 N 8v1te 31. Date filed (Month, Dav. Year. 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 29d per doc g917 7-18-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201 Physician/ Month AXMANA 10AM 06 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ARE SYSTEM VA MARYL Hoint HEALTY COLA SC 8. Date of Birth (Month, Day, 14) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** ^{Year]}1919 1**X** M 2 □ F Months Days Hours Min. 214-18-9788 Yrs. Iowa Director 91 Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Shrewsbury PA York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 17361 254 Prospect Circle U.S.A. Was Decedent L. Armed Forces?

1 El Yes 2 No 4 2 Yes, Give 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 5-0036 White 1 ☐ Yes 2X No Specify: 3 Divorced Completed LAE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Mail Sorter U.S. Government 12 Ш Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Gertrude E. Melaney Milton M. Saxmann 22d xxd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 254 Prospect Circle Shrewsbury, PA 17361 <u> Steven Saxmann/Nephew</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of June l 20c. Location - City or Town, State 6, Cremation Direct 1 Burial 2 X Cremation 3X Removal from State 2011 4 Donation 5 Other (Specify) York, 22. Name and Address of Facility JJ Hartenstein Mortuary, Inc. Signature of Funeral Service Licensee 24 N. Second St. New Freedom, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ resitanitis disease or condition Wecks Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): signed by the attending physician and a be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Live Each in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown eral Director: After this certificate has been si filled in by the funeral director, page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? After this certificate 2 🗌 No 1 Yes ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina Accident Investigation within 24 hours after death

To the Funeral Director: ,
completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Hum MD H0054439 6-14-2011 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Incent A. Giminaro, Do VA Maryland-Perry Point, Maryland 31. Date filed (Month, 32. Registrar's Signature State Registrar

X

			for State Registrar	State of Ma	aryıanı	•	tificate of	Death	ментаг пу	Reg. No.		
П	Physicia	n/	1. Decedent's Name (First, Middle, La BARCLAY H. TRIP	•					2. Date of De		Year	3. Time of Death
	Medic	al	4a. Facility Name (if not institution, give				4b. City Town	or Location of Death	JUNE 2		County of Death	11:00 A ^M
ر	Examin	er	27387 TRIPPE ROA					ASTON		40.0	TALBOT	
Ī	Funeral			Sex 7. Age	(In yrs. la	st birthday)	If Under 1 Year Months Days		8. Date of Bir	th	9. Birth	place (State or Foreign
	Director		Usual Residence of Decedent	TAC WIZ CIT	0/	Yrs.			JULY 3	1,192	23 MARY	LAND
	land show dat	호	10a. State 10b. County		10c. City	, Town or Loc	cation			-	1	10d. Inside City Limits
	Mary 28a-f otifie	irec	MD TALBO)T			EASTON	T				1 ☐ Yes 2 👿 No
	ith the 23a or st be r	ra D	10e. Street and Number	ND.			10f. Zip Code	21.601			en of What Cour	ntry?
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0	ifter de ", or it amine	ğ	1 Never Married 2 X Married	Armed Forces? 1 X Yes 2 If Yes, Give	No		f Yes, specify Cub ☐ Yes 2 👿 N		Rican, etc.)		Black, White,	
2-003g	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	3 Widowed 4 Divorced 15. Decedent's	Year or Dates.			lent's Usual Occu					ITE
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סמ	permit, Pa Departmer Important any injury once,		21. Signature of Finde al Service Lice	yee)	101			ess of Facility 200				
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_	Physician/		Immediate Cause (Final				ATIC CAN	_			,	Interval Between Onset and Death MONTHS
	Medical Examiner		disease or condition resulting in death)	Due to (or as a			MIIO OM	TOLK				HONING
		er	Sequentially list conditions,	D			R CANCER	₹			3	YEARS
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000		E	IF FEMALE:	23c. If yes, outcome of	of pregnar	nev						
YOU	attend for us	Completed by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 4 Pregnant at	2 🗌 Fetal	death 3	Ectopic pregnar Other (specify)	псу		23	3d. Date of delive Month	ery Day Year
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5	ing Ph .fter th .neral		27. Manner of Death 1 ▼ Natural 5 □ Pending	28a. Date of injur (Month, Day)		28b. Time of injury	28c. Inju wor	k?	28d. Describe h	ow injury c	occurred	
	ttend death ctor: A / the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not	be 290 Place of Injur	ny - At hor	na farm stra		Yes 2 □ No	20f Location (S	Stroot and I	Number or Rural	Pouto Number
	al or A s after I Direc d in by		4 ☐ Homicide determined	building, etc			et, factory, office		City or Tow		vurnber or Hurar	Houte Number,
-	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier 1 Certifying Ph (Check 2 Medical Exam	ysician: To the best of o	ny knowle	edge, death o	ccured at the tim	e, date and place, ar	nd due to the ca	use(s) and	manner as state	d. use(s) and manner stated.
	the H thin 24 the F mplete	Me	only one) 3 Certifying Nu	rse Practioner: To the b			eath occurred at t	he time, date and place	ce, and due to th	e cause(s) a	ind manner as st	ated.
			29b. Signature and title of certifier	+ 110			29c. Licens				signed (Month, i	
	TO LVA		30. Name and address of person who	completed cause of de	ath (Item	23a) (Tvoe. P	rint)	059939		0 6	0-02-	2011
	20+VA		ESELLIOH, MD	Miles Rive	er Ph	145/1010	15 508	Idlewild	Avenu	2 80	ston, M	ld 21601
	Stat Registra		31. Date filed (Month, Day, Year) JUN 0 7 2011	MILES RIVE	r's Signatu	par						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ PM THOMPSON 1:12 JUNE 2011 ERNESTINE Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORE HOSPITAL RANDALLSTOWN NORTHWEST If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Days Hours 05/11/1947 Months Min 64 Vrs 213-54-2141 **Director** Usual Residence of Decedent 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medi-al Examiner must be notified at 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director Yes 2 No Windsor Mill Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral 21244 USA 7906 Dunhill Village Apt.202 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 Yes 2XXNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 XNo Specify: Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Sinai Hospital Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F t. Page 1 and 2 should be file tment of Health and Mental tant: If item 27 Is marked of ٥ Herbert D. Bazemore Maddie Seller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 19a. Informant's Name/Relationship (Type, Print) 7906 Dunhill Village#202 Windsor Mill,MD William Moore/ Friend 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any Injury or o Bazemore Fam. Cem. 6/11/2011 Bertie Co., NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cherry Funeral Home 21. Signature of Funeral Service Licenses 308 East George St.Windsor, NC 27983 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between nock, or heart failure List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death SEPSIS Physician/ Medical Due to (or as a consequence of): Examiner COLITIS CLOSTRIDIUM DIFFICILE Sequentially list conditions, if any, leading to immediate cause: Enter Underlying Examiner Due to (or as a consequence of) NEUTROPENIA The law requires that the death certificate be executed Cause (Disease or linjury ohysician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day Prègnant at time of death Yes detached the Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I þ COLON CANCER STAGE III 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? _2 **W**No 1 Yes Yes or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' 2 Y No Hospital Other: မ 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. injury at 28d. Describe how injury occurred iniury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nufse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Dav. Year) 29b. Signature D0060293 of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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RANDAUSTOWN MD 21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 2011 15:12 P M June 4, Chauncey Dewey Terry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthdav) **Funeral** Months 1 X M 2 □ F Hours 47 Yrs 1963 **Director** Sept. 579-88-2502 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director ms 23a or 28a-f s must be notified Suitland 1 Kyes 2 No Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with United States 20746 3440 Wood Creek Drive Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, et-1 Yes 2 No ō þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 **Black** nan "natural", Medical Exan 1 ☐ Yes 2 ANO Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15, Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Self-Employed Sales Consultant traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Willimena Doris Johnson Dewey Terry John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3440 Wood Creek Drive Suitland, Maryland 20746 1 and 2 s of Health Joyce Terry Butler - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. Page 1 ₹ etery, crematory or other place 1 ABurial 2 Cremation 3 Removal from State June Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Fureral Service Licensee 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ MYOCAMIA L disease or condition resulting in death) Medical as a consequence of Examiner Color of the state Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No the 9 Unknown Unknown requires that the P.0. as been signed by the 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page perform 1 ☐ Yes 2 ☐ No 1 Yes Physician; 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 D No s after death.

I Director: After this cond in by the funeral dire Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State

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son who completed cause of death (Item 23a) (Type, Print)

Registrar

only one) 29b. Signatu

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mont 06 ŽÖ11 0514 ďľ Ralph Norman Weller Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Carroll Westminster Carroll Hospice Dove House If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ Days Hours Min. 06/18/1917 WV Director 218-32-1354 93 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examinar minet has actived a contraction. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1X Yes 2 ☐ No Carroll Westminster MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 USA 250 St. Luke Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: 3 Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Self-employed Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 G. Allen Weller Susan Catrow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Allen Weller, son 2236 Greensburg Road, Martinsburg, W 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Westminster, MD Westminster Cemetery 06/07/2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel The 21157 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the fine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnanti 9 ☐ Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 Yes 2 No 1 🗌 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Ched only Certifying Nutse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I 29b. Signature and title of certifier WJL 15 Flavio Kruter, of death (Item-23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day

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State of Manyland / Department of Health and Mental Hygiene

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	Physicia I Exami		Decedent's Name (First, Midd Dean Edwin	_						2. Date of Dear Month June 10, 2	Day Yea		3. Time of Death 0857 hrs
			4a. Facility Name (if not institution 6711 - 6 Bailey Store				4b. City, Town		n of Death		4c. County		
	uneral irector		5. Social Security Number 234-88-9673			ast birthday) 51 Yrs		Year If Ur Days Hou	nder 24Hrs. urs Min.	-	th _(MM/DD/YYY)	Foreign	
	any	ŀ	Usual Residence of Decedent 10a. State 10b. County			Town or Loca				J			10d. Inside City Limits
	A	5		chester			'edera	lsbur	g				1 Yes 2 No
	or 28a-f	Director	10e. Street and Number 6709 Bailey	Store Road	3		10f. Zip Co	_{de} 21632	2		og. Citizen of Wi United		
	death with the Maryland or items 23a or 28a-f shn must be notified at once.	Funeral [11. Marital Status 1 Never Married 2 N	12. Was Deceden Armed Forces	t Ever in U	.S. 13. W		f Hispanic C	rigin? (Sp	ecify Yes or No Rican, etc.)		- Americ e, etc.	an Indian, Black,
4	ral", or i		3 Widowed 4 Di	vorced If Yes, Give Year 1 or Dates:	□ No 34-80	0 1 -	Yes 2				Specify:		ite
36	Hygiene. Inther than "natural", the Medical Examiner	Completed by	15. Decedent's Education (Spe Elementary/Secondary (0-12)			during a	nt's Usual Occ nost of working ICtion	life. DO NO	T use retir	red)	Solo (Company
MD 21215-0036	I and a smoot or tited within 1, nours arter ceam win the Maryland Health and Mental Hygiene. Item 27 is marked uther than "natural", or items 23s or 28s-f shi tranmatic event, the Medical Examiner must be notified at once	Ве Соп	17. Father's Name (First, Middle Jack E. Woo	e, Last) ods				Laı	ıra N	Mae Ro		,	
AD 21	2 should h and Me 27 is ma matic ev	٩	19a. Informant's Name/Relation Loraine Wood								mber, City or Tow er, DE		
ē.	S = = =	İ	20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Other S	n 3 Removal from Si	ate	Place of Dispo crematory or o tem Sh.	ther place)			Date 17/11	20c. Location		Town, State Maryland
Balti	permit. rage Department c Important: injury or nth		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federal Sourg, MD 21632										
/N	ysician Iedical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease										
X	aminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons									
		iner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence o	of):							
	d ansit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence o	of):							
· 60,	ne be executed hysician and e burial - transit	Medical	UNPENDED	AMENDED									
Box 6876	It a net bigging or Artending Prysician: The taw requires that the cean centricate be executed within 24 hours after death, To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Ur	the 23c. If yes, outco		2 Fe	etal death other (Specify,		pic pregna	ncy	23d. Date o Month	•	ay Year
P.O. B	s that the d gned by the detached		Part II. Other significant condi		th but not r	esulting in the	underlying ca	ise given in	Part I.		obacco use controls 2 No 3		he cause of death?
Division of Vital Records,	has been sign 2 should be	Completed by								24a. Was autop perfo	psy		opsy findings available ompletion of cause of
E Re	certificate ector, page		25. Was case referred to medic	al			26.1	Place of Dea	th (Check		2No1	✓ Ye	s 2 No
f Vit	raysica er this ce eral direc	To Be	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpati	ent 2	ER/Outpatien		Other			Residence 6 how injury occur		Scene
ion	Attending knysicia r death. cetor: After this ce by the funeral direct	ation	1 V Natural 5 Per	(Month, Day, anding estigation	Year)		1	Yes 2					
Divis	ours after ours after neral Dire filled in b	Certification:	4 Homicide det	ald not be ermined (Specify)	njury - At h	ome, farm, stre	eet, factory, of	fice building	etc.	28f. Location (or Town, S		er or Rur	al Route Number, City
;	In the Bus within 24 h To the Fur completely	Medical	29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the best of naminer: On the basis of examiner and manuer stated	ny knowled amination a	lge, death occu and/or investiga	urred at the tin ation, in my op	ne, date and inion, death	place, and occurred a	due to the cause t the time, date	se(s) and manne and place, and	r as state due to the	ed. e cause(s)
	4 ≯ F4 S	Me	29b Signature and title of certif					cense numb	er		29d. Date sign June 11, 2		nth, Day, Year)
1,1			30 Name and address (* perso	n who completed cause of Deputy Chief Med			n W. Baltin	nore Stro	et Raltin	nore, MD 2	1223		
171 0	OME	tate	Mary G. Ripple MD. 31. Date filed (Month, Many ea	Deputy Chief Med			O W. Bailin		or, Dailli				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g917 7-8-11 vt
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June June 2011 Joyce Ann Ward 4:10 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Caroline Denton 1010 Suzanne Street 8. Date of Birth **1938** (Month, Day, Year) May 19, 1939 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) Maryland Months Days Hours 1 M 2 XF Yrs Director 214-36-5654 Usual Residence of Decedent 28a-f shov 10b. County filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No <u>Maryland | Caroline</u> Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1010 Suzanne Street 21629 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🕅 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Divorced Completed White Year or Dates other traumatic event, the Medical 15, Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) District Court Clerk Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hv.
Important: If item 27 is many injury or other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ Carl Nichols Ruthanna Schultie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David C. Ward, Sr. 1010 Suzanne Street Denton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Greensboro Cemetery 4 ☐ Donation 5 ☐ Other (Specify) June 8, 2011 | Greensboro, Maryland of Funeral Service Langue Auchor 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final 2 Onset and Death hysician/ ANCER disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. First Industry a Cause (Disease or linjury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law equires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes No Month Day Year 1 ☐ Yes 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has l autopsy performed 2 🗌 No Yes 2 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 **P**No 1 🗌 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) I Director: After to d in by the funera Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2011 D08118 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNMOLIS STANWY KINS MEDICAL 31. Date filed (Month, Day, 2. Registrar's Signature State JUN U 8 2011 Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
mend #105-f Per FH G917 7/05/2011 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Patricia Wholey 7:10 AM June 8 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Talbot Hospice House Talbot Easton Birthplace (State or Foreign Country) Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days (Month Day, 1 - M 2 X F Months Hours 726-14-7666 82 Yrs **Director** May 1929 Winnipeg, Manitoba Usual Residence of Decedent show Prince George's City, Town or Location Landover Hills Easton 10a. State with the Maryland notified at 10d. Inside City Limits Director 28a-f Maryland 1 X Yes 2 No 10e. Street and Number Allison Street 586 Cynwood Drive 10f. Zip Code 5 10g. Citizen of What Country? must be Funeral 23a 21601 20784 IISA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygene. Important! If item 27 is marked of the and injury or out. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: White 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) National Academy Elementary/Seconday (0-12) College (1-4 or 5+) of Sciences Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary Cullen William L. McIntyre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13197 Highland Road, Highland, MD 20777 James P. Wholey / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Metropolitan Crematory 1 Burial 2 X Cremation 3 Removal from State 6/9/2011 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue RAY RUGERS Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset an Death letastatic Physician/ Colon cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical The law requires that the death certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month Day Year Pregnant at time of death Other (specify) 4 ☐ Pregnant 9 ☐ Unknown the Division of Vital Records, P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available 24a. Was an nas autopsy performed? Yes 2 No prior to completion of cause of death?
1 ☐ Yes 2 ☒ No certificate Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other Hospital: House 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of within 24 hours after death.

To the Funeral Director: After t completed filled in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 ☑ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) another 8 2011 June 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAKSHMI VAIDYANATHAN 219 S.WASHINGTON ST MD - 2160 EASTON 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

JUN 1 0 2011

32. Redistrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla	na / Depa <i>Cer</i>	artment of tificate of	Death	Mental Hy	Reg. No.		20125
	Physicia	an/	1. Decedent's Name (First, Middle, Last)					2. Date of De	eath	Voor	3. Time of Death
,	Medic	cal	Bonnie E11 4a. Facility Name (if not institution, give si		Aikman			June		2011	5:20 P M
	Examin	ier	Brighton Gardens	,	zino		or Location of Deatl yy Chase	n	4c. County		gomery
7	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Day	r If Under 24 Hrs.		rth	9. Birl	thplace (State or Foreign
	Director	ļ	579-42-4129 Usual Residence of Decedent	77	Yrs.	month Day	Thouse I will	Oct. 2	0,1933	Ne	braska \
	/land f shov ed at	ţ	10a. State 10b. County		ty, Town or Loc		77				10d. Inside City Limits
	r 28a- notifie	Director	MD Montgom	ery	_	Chevy (nase				1 🛛 Yes 2 🗆 No
	with the s 23a o	Funeral	5555 Friendship	Blvd.		10f. Zip Code	20815		10g. Citizen of V		
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inmportant: I firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ↑ Never Married 2 ↑ Married 3 ↑ Widowed 4 ↑ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates.	Н	Vas Decedent of Yes, specify Cu	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		k, White	erican Indian, e, etc. White
2-0	2 hour "natur edical	Completed	15. Decedent's Edu (Specify only highest grad	ıcation	16a. Deced	ent's Usual Occu	pation during most of wor	tkina	16b. Kind of Bu	usiness	Industry
121	ithin 7; ene. • than he Me	Som	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. DO	O NOT use retire	d)		Fodor	1	Government
d 2	iled will Hygin other vent, t	Be	17. Father's Name (First, Middle, Last)	4	[FUDI	IC AIIa	rs Office		, Maiden Surname		Government
ylar	ild be f Menta narked atic e	오	Cornelius H	oward Ai	ikman		Honora	Đ.	Ellen		Towey
Baltimore, Maryland 21215-0036	2 shouth and the and the street is a street the street		John E. Aikman /		-1		t and Number or Ru nia Church				
re,	1 and of Hea item other		20a. Method of Disposition	20b.	Place of Dispos	sition (Name of		Date Date	20c. Location -		
timo	Page tment tant: If jury or		1 ☐ Burial 2 【XCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Ch		ke Crema		/22/2011	Belts	vil	le, MD
Bal	Depart Impor any in		21. Signature of Tuneral Service Licenses		18 9	Name and Add app fund 33 Gist	eral and (Ave., Si	Crematio Lver Spr	n Servic	es 2	0910
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only one	cations that caused the dea cause on each line.	th. Do not ente	r the mode of dy	ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
P	h sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	METASTAT		AST CANO	CER				Onset and Death 7 YEARS
	Examiner		Cogusatially list on divisor	Due to (or as a conseq	derice oi).						
7	sit s	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):						
760	physician and sthe burial-transit	Exal	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
90	nysicia ne buri	dical		l							
687	ding ph	/Me	IF FEMALE:	o If you outcome of progn	an av			_			- 1
Division of Vital Records, P.O. Box 68760	The property of when the property of the prope	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	3c. If yes, outcome of pregnation 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregna Other (specify)	ncy		23d. Da		livery Day Year
P.O	ned by detac	by Ph	Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	nderlying cause (given in Part I.	23e. Did t	obacco use contr	ribute to	the cause of death?
ds,	en sig	ted t	1					1 🗆	Yes 2 X No	3 🗆 P	robably 4 🗆 Unknown
Recor	cate has be page 2 sho	Completed				· • ·		24a. Was auto perfe	psy ormed?	orior to d death?	topsy findings available completion of cause of
tal	sertifica ector, p	Be	25. Was case referred to medical examiner?	ospital:			Place of Death (Che		2.24(10)		2 110
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	r this c	<u>و</u>	1 ☐ Yes 2 🔀 No Proceed to 1 ☐ Yes 2 🛣 No Proceed to 1 ☐ Yes 2 🛣 No Proceed to 1 ☐ Yes 2 ☐	1 Inpatient 2 28a. Date of injury	ER/Outpatien	t 3 DOA Ot			dence 6 Othe		eify)
ono	eath.	ficate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	wo	rk?] Yes 2 No	28d. Describe	how injury occurre	3 a	
Divisi	rs after de al Directo ed in by ti	l Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		et, factory, office		28f. Location (City or Tou		er or Rui	ral Route Number,
Hoepi	n 24 hou le Funer	Medical	(Check 2 Medical Examine	ian: To the best of my knower: On the basis of examination of the praction of the best of me	in and/or investi	dation, in my opir	ion, death occurred:	at the time, date :	and place, and due	e to the c	cause(s) and manner stated
ام ام	Vithi To th		29b. Signature and title of certifier	n/2	-0-,0	29c. Licen	se number		29d. Date signed	d (Month	h, Day, Year)
	(0 gm		Infuh L	JO Jan M	10		22775		JUNE	21,	, 2011
	22		30. Name and address of person who cor FREDERICK G. BARR				#1300, C	HEVY CHA	ASE, MD	20	0815
i	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture La Ke	1					

11-04356 Chad Anderson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 20126 State of Maryland / Department of Health and Mental Hygiene

	1- For State Registrar		Certific	ate of I	Death			F	Reg. No.				
Physician/		fle,Last)					2.	Date of Dea	ath Day	Year	3	3. Time of Death	
Medical Examiner	Chad E. Anders	on						June 9, 2		1001		2357 hrs	
	4a. Facility Name (if not instituti	on, give street and number)		4b	. City, Town, or	Location of	Death		4c. (County of [Death		
	Sinai Hospital				Baltimore					I/A			
Funeral	5. Social Security Number	6. Sex 7. Age	(In yrs. last bir	thday)	If Under 1 Yea			8. Date of B	irth(MM/DI	2/YYYY) ⁵	9. Birth Foreign	place (State or	
Director	212-08-9650	1XM 2□F 26		Yrs.	Months Day	s Hours	Min.	Jan.	10 1		Cour	Maryland	
	Usual Residence of Decedent							oan.	10, 1	2001		rary.tana	
any	10a. State 10b. County		10c. City, Town	or Locatio	n						1	10d. Inside City Limits	,
AG -F	Maryland N/	Δ	Baltim	oro								1 X Yes 2 No	,
Maryland 28a-f show 1 at ouce.	Maryland N/A	.1	Dalli		10f. Zip Code				10g. Citize	n of What	Counti	ry?	_
the Maryland a or 28a-f sh tified at one Director													
17215-0036 Id be filed within 72 hours after death with the Maryland dental Hygiene. narked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must he notified at once. De Completed by Funeral Director	5018 Queens Bo	erry Avenue 12. Was Decedent B	Supr in LLC	13 \0/05	21215 Decedent of Hi	enanic Origi	in2 / Snec	ify Ves or N	USA	4 Race -	America	an Indian, Black,	_
r death with or items 23, or items 23, must he no	1 Never Married 2 N	Armed Forces?			s, specify Cuba				Ĭ	White, e		arranari, Elasti,	
F. or i	3 Widowed 4 Di	1 Yes 2 vorced if Yes, Give Year	X No		∕es 2 <mark>X N</mark> o	specify:			s	pecify: B.	lack	ς	
iral y	45 December 19 Education (Co.	or Dates:	oleted) 16a		Usual Occupa		ind of wor	k done		nd of Busin			_
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12				st of working life				102.74				
36 in 72 han 'han '	Elementary/Secondary (0-12	College (1-4 of 5							N.	I/A			
with with Mee the	10th Grade) Last)		Unemp	loyed	18.Mother's	Name /F	irst Middle		-			_
THyge							•			arriarrio,			
21215-0036 hould be filed within 77 in Mental Hygiene. is marked other than intervent, the Medical To Be Comple	Edward Earl At	nderson	10	h Mailing	Address (Stre			arter		or Town	State	Zin Code)	_
D 21 should I and Mer					,								
MD and 2 sho alth and m 27 is aumati	Celeste Anderso	on/Mother	20h Place	of Dienositi	n (Name of ce	Berry		ue Ba	Ltimo	re, M	ity or T	own, State	_
S l a si the site of the site	1 X Burial 2 Crematic	n 3 Removal from Sta		tory or othe		inotory,		Julio	200.20		,	, 5.2.6	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. nut: If item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner mut he notified at once To other traumatic event, the Medical Examiner mut he notified at once To Be Completed by Funeral Director	4 Donation 5 Other S	Specify:	King	Mem	orial	Park	6-17	-2011	Bal	timo:	re,N	MD	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other it injury or other traumatic event, the Med	21. Signature of Funeral Service	Licensee	risks a Michigan	22. Na	me and Addres	s of Facility	Chat	man-H	arris	Fune	era.	l Home	
ದ ಕೃತ್ವಾ	Gillen Ham	5240 Reisterstown Road Baltimore, MD											
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
\/Weaical	Immediate Cause (Final diseas	Marking Complet Marindo											
Examiner	or condition resulting in death)	Due to (or as a conse											_
	Sequentially list conditions,	b									_		_
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ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):								_		-
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1760, ficate be executed 3 physician and the burial - transit	UNPENDED	AMENDED											Τ
760, ficate be g physici the buri	IF FEMALE:	23c. If yes, outcom	e of pregnancy						23d	Date of de	eliverv		- 1
876 tifica ng pk as the	23b. Was decedent pregnant in past 12 months?				I death 3	Ectopic	pregnanc	у		fonth	Da	ay Year	
th cer trendi	past 12 months:	4 Pregnant at t	ime of death	5 Othe	er (Specify)								
the death certife the death certife by the attending toched for use as Physician	1 Yes 2 No 9 U	9 Unknown			_				_1_				-
P.O. that the med by detach		itions contributing to death	but not resulting	ng in the un	derlying cause	given in Par	rt I.					ne cause of death?	
sign 1 be d					-								
requirements								24a. Was	s an opsy			opsy findings available impletion of cause of	9
Records, i. The law requires ficate has been sign, page 2 should be Completed				-					ormed?		ath? ✔ Yes	2 No	
St. Pa		al			26.Plac	e of Death (Check on				/		_
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi ledical Certification: To Be Completed by Physician/Medical Es	examiner?	The state of the s	nt 2 🗸 ER/C	Outpatient	3 DOA	Other ₄	Nursing I	Home 5	Residen	ce 6	Other:		7
of Virthysis ter this eral dir	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injur	y 28b.	Time of Inj	ury 28c. Inju	ury at Work?	? 2	3d. Describe	how injur				_
th. Af	1 Natural 5 Per	Jun 9, 2011	^{ear)} 231	7 hrs	1	Yes 2	No Si	ubject sh	ot				
Sic Atter r dear ector by th	2 Accident Inv	estigation 28e. Place of Inj	urv - At home. f	farm street	factory, office	building, etc	2	3f. Location	(Street and	d Number	or Rura	al Route Number, City	,
Division or spital or Attending tours after death. neral Director: After filled in by the func Certification:	3 Suicide 6 Co	uld not be ermined (Specify) Loc		,	,,,	g,		or Town,	State)				
S copits	/98 (entitle)	Physician: To the best of my		adla a sauran	and set the stime of	tata and nin							-
To the Ho within 24 To the Fu completel	(Check only 1 Certifying one) 2 Medical Ex	aminer:On the basis of exam											
Tot Tot	29b. Signature and title of certif	and manner stated			29c. Licen	se number			29d. Da	ate signed	(Mont	th, Day, Year)	_
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	Zabiullah Ali, M.D.	Assistant Medical Ex		JU VV. B	ammore Str	et, Daith	inore, IV	ID 2 1223					_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 615pm Medical 06 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospita Center Himore le **Funeral** 7. Age (In vrs. last birthday) 048-30-2054 8. Date of Birtl 9. Birthplace (State or Foreign Country) **Grenada** 1 □ M 2**X**XF Months Davs Hours Min. 6/1254.1938 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21229 1224 Violette Avenue 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces

1 ☐ Yes 2 ☐ No Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 X Divorced Specify:White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Manufacturing Chemist Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grillo Ιvy Unknown Winsborrow Arg, wette, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4005 Marjeff Pl., Apt 5 Baltimore, MD 21236 James E. Mullen, Jr. (son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metro Crematory Inc. 6/23/2011 Baltimore, MD Lassann de Funéral Home, Inc. /401 po Baltimore, MD Signature of Fame al Savice Licensee Inc. 7401 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Infarction ocardia Medical resulting in death) Due to (or a la consequence of) Examiner Coronary Artery
Due to (or as a consequence of): 20 years Sequentially list conditions, If any leading to fin mediaticause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the at d be detached for Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should ! Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the director, page 2 s performed? Yes 2 X No 1 Tyes completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🕅 No Other: 1 Inpatient 2 K ER/Outpatient 3 IDOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 🗆 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 06/22/2011 D5097 Gar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10910 Little Aco B CHERIAN

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Y JUN 2 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Richard Virgil Bridi June 21 2011 1:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Potomac Valley Nursing Center Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 7, Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Year **X**XM 2□ F Yrs. Sept. Director 180-22-6002 82 1928 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show ir than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at Director MD 1 ☐ Yes 2 ☐ No Montgomery Silver Spring, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14400 Homecrest Rd. 20906 United States by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 XYes 2 No If Yes, Give Year or Dates: Korea 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo White Specify: 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Chemical - Plastics Salesman traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be f and Mental Bridi Beniamino Carmella Zinzarella ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If item 27 is any Injury or other trau 2728 Blaine Dr., Chevy Chase, MD Barbara B. Frampus / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory 06/22/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Rapp Funeral and Cremation Services Steph Adaman 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the dis se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MONTHS DEMENTIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or infury) Examiner Due to (or as a consequence of): as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ò Month Day Year 5 Other (specify) ☐Yes 2☐No detached 1 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 🐉 🗓 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes XXNo ပ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? :io After 28d. Describe how injury occurred or Attending 1XXNatural Injury 5 Pending after death.

I Director: Ald in by the fur investigation 1 ☐ Yes 2 ☐ No Certificati 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O,

Maryland 21215-0036

Baltimore,

Box 68760.

Ö

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Division of Vital Records,

D38262

2401 RESEARCH BLVD. #330, ROCKVILLE, MD

JUNE 21, 2011

20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 20129 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06 2011 James G. Buttner 20:39 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Bel Air Upper Chesapeake Medical Center 6. Sex 1 M 2 D F Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 03/24/1949 Yrs Director 213-52-9553 62 Maryland Usual Residence of Deceden 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location must be notified at 10d. Inside City Limits Funeral Director 1 Yes 2 No Baltimore MD Kingsville ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a U.S.A. 12016 Belair Road death \ 12. Was Decedent Ever in U.S.
Armed Forces?

1 🕅 Yes 2 No
If Yes, GiveVietnam
Year or Dates. Era Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. 0 Completed by 1 XNever Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Carpet Cleaning Business Self-Employed Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 7 is marked of 2 Melvin Jay Buttner Patricia Barry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 Health tem 27 Page 1 and 2 (brother) 2405 Chesterfield Avenue - Baltimore, Maryland David Buttner Department of Heall Important; If item 2 any injury or other 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/25/2011 | Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ discar Dulmonan disease or condition resulting in death) Medical ue to (or as a consequence of) **Examiner** acidos Secuentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Completed by Physician/Medical Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Hoknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2.12 No Other: 1 Yes ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending (Month, Day, Year) 1 🗆 Yes 2 🗆 No neral Director; A I filled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours To the Funeral L Medical 29a. Certifier r 📴 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapeake Drivi, BU Avi, Mayland "MD UP 500 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

SOB,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 2011 20130

		- For State egistrar				Certific	cate of	Death					Reg. No	,		
Physicia		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day											Yea		3. Time of Death	
ledical Examin		JOHN BYRNE										June 19,	2011			1206 hrs
\supset		la. Facility Name (if not institution 2805 Bayonne Avenue		treet and nu				Baltim		ocation of				c. County o		
Funeral Director		5. Social Security Number 216-56-4231	6. Sex	1 2 F	7. Age (Ir	yrs. last b	oirthday) Yrs.	If Unde Months		If Under Hours	24Hrs. Min.	8. Date of B			9. Birth Foreign Cou	
any		Usual Residence of Decedent 10a. State 10b. County			100	: City, Tow	vn or Locatio	n			_				T	10d. Inside City Limits
		MD N/A				BAL	TIMORE									1 X Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number 2805 BAYONNE A	VE					10f. Zip 212					10g. Ci US	tizen of Wh	at Count	ry?
eath with the items 23a ust be noti		11. Marital Status 1 X Never Married 2 Ma		12. Was De Armed F	cedent Ever orces?	er in U.S.	If Ye	s, specify	Cuban, I			ify Yes or N can, etc.)	10-	14. Race White	, etc.	an Indian, Black,
after d) 교			Yes, Give Ye or Dates:	ar			Yes 2		specify:			1401	Specify:	WHIT	
72 hours "natu	Completed	Elementary/Secondary (0-12)	cify only		(1-4 or 5+)	ted) 16	a. Decedent during mo DISAE	st of worl					160.	Kind of Bu	siness/ir	dustry
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than event, the Medics	Be Con	17. Father's Name (First, Middle, JOHN BYRNE	Last)						18	B.Mother's PAT	Name (F	irst, Middle A GES	Maide SNEF	n Surname		
imore, MD 2121: Pages 1 and 2 should be filment of Health and Mental I lant: If item 27 is marked or other traumatic event.		19a. Informant's Name/Relations PATRICIA WHETZ			₹	- 1	700 W.	BEI	AIR	AVE	APT	209	ABERDEEN, MI 20c. Location - City or 7			21001
Baltimore, ME seemit Pages I and 2 s Department of Health a Important: If item 27 inportant or other traum.		20a. Method of Disposition 1 Burial 2 X Cremation		Removal f	from State		e of Disposi natory of oth ANTIC					Date 4/11	- 1		-	Town, State LE, MD
Baltimo permit Page Department of Important: injury or otl	-	4 Donation 5 Other Specify: 21. Signature of Funeral Price Licensee 22. Name and Address of Facility MILLER-DIT PEL F 6415 BELAIR RD BALTIMORE, MD										MD 21	206	HOME, INC		
Physician /Medical		23a. Part Enter the disease, or failure. List only one cause	on each	n line.					of dying, s	uch as ca	rdiac or r	espiratory a	rrest, s	hock, or he	art	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	_	theroscle ue to (or as		_	cular Dise	ease								
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		ue to (or as	a consequ	ence of):					_					
The dead of the sansit	Examiner	(Disease or injury that initiated events resulting in death) Last	d.	ue to (or as	a consequ	ence of):				-		-	_			
760, icate be executed physician and the burial - transit	Medical	UNPENDED		AMENDED)											
D.O. Box 68760, that the death certificate be need by the attending physici detached for use as the buri	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Un	ne known	4 Preg	birth gnant at tim		2 Fet	al death ner (Spe		Ectopic	pregnand	су	2	23d. Date of Month		ay Year
P.O. B es that the d igned by the	by Ph	Part II. Other significant condi			to death b	ut not resu	Iting in the u	nderlying	cause gi	ven in Pa	rt I.		tobaco			the cause of death? ably 4 Unknown
cords, aw requir nas been s 2 should b	Completed by		-									pe	as an topsy rformed s 2 ✓	?	Were au prior to c death?	topsy findings available ompletion of cause of
I R	ပ္တ	25. Was case referred to medica	ıl l					_	26.Place	of Death (Check or					
/ita /sicia nis cer direct	o Be	examiner? 1 ✓ Yes 2 No	Ho	spital: 1	Inpatient	2 EF	R/Outpatient	3 [OOA	Other ₄	Nursing	Home 5	Resi	dence 6	Other	: Scene
on of Vending Phy ath. or: After the	Certification: To	27. Manner of Death 1 Natural 5 Pen	ding	(Mon	te of Injury hth, Day,Year		Bb. Time of I	njury		y at Work es 2		28d. Describ	e how i	injury occur	ed	
Division Hospital or Attendia 24 hours after death. Funeral Director: A	ertifica	3 Suicide 6 Cou	stigation ld not be ermined	28e Pla		y - At home	e, farm, stree	et, factory	, office bu	uilding, et	c. 2	28f. Location or Town			er or Ru	ral Route Number, City
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Example Certifying F	miner:	n: To the be On the basis	s of examir	nowledge, nation and/	death occur for investigat	red at the	e time, dat y opinion,	te and pla death oc	curred at	lue to the ca	ause(s)	and manne place, and	r as state	ed. e cause(s)
5. i.w. 6. 00	Me	29b. Signature and title of certific			-			29	c. License					d. Date sigr une 20, 2		nth, Day, Year)
		30. Name and address of person Jack Titus MD. De					^{3a)} 900 W. I	L_ Baltimo	re Stre	et, Balt	imore.	MD 2122	23			
St	ate	31. Date filed (Month, Day, Year,			Registrar's											
Regist	rar	JUN 2 4 2011	1	سليب	<u> </u>	pa	Nel									

/land 21215-0036	n 72 hours after death with the Maryland	denic of reaching and montain regions. The most service of the ser
timore, Maryland 21215-0036	t. Pages 1 and 2 should be filed within	rient: if item 27 ie marked other then lury or other traumatic event, Lisher

		4	1 - For State Registrar	State of Marylan	_	tificate of I			Reg. No.						
	Physicia		1. Decedent's Name (First, Middle, Las		YRD			2. Date of Dea Month	Day	Year 2-01	3. Time of Death				
	/Medic Examin		4a. Facility Name (If not institution, give		1.50	4b. City, Town, or	Location of Deat								
			7527 Lange Stree	t			timore (В						
	Funeral		Social Security Number 6. S	ex 7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, Year)	9. Birthp	lace (State or Foreign				
	Director		213-32-9696	79	Yrs.			May 9	1932						
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if item 27 ie marked other then "natural, or iteme 23a or 28a-1 show enty injury or other traumatic event, it is Mudical Examination to inditied at ODGe.	ctor	Usual Residence of Decedent 10a. State 10b. County MD Ba1	10c. City	, Town or Lo	cation	Baltin	ore Co.		1	0d. Inside City Limits 1 ☐ Yes 2X No				
	or 28	Olre	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	itry?				
	23a	Funeral Director	7527 Lange Str	eet		21224									
	ar deg	nue	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)	- 14. Ra						
0000	nours afte	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:				White				
'n	"nat	lete	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo √1	rking	16b. Kind of	Business/In	dustry				
7 7	withilene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		maker	-/		Oran	Uomo					
	Hyg other ent,	e e	17. Father's Name (First, Middle, Last))	Home	maker	18. Mother's Nai	me (First, Middle,		_					
yland	uld be Aenta rked ric ev	To B	Fred	Claar			Mart	:ha	Koone	:S					
=	and h		19a. Informant's Name/Relationship (Code)				
	is 1 and 2 of Health a item 27 ie other trau		Carol Polomski			Pinewood									
9	ges 1 I of H if iten		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	lace of Dispo emetery, cren	sition (Name of matory or other plac	ce)	Date	20c. Location	n - City or To	own, State				
	tmen tent:		`4 □Donation 5 □ Other (Specif		-	Cemetery		7/2011	Balti	more,	Maryland				
baitimore,	Depar Impor eny in		21. Signature of Fureral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, I 7922 Wise Ave. Dundalk, Maryland 21												
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.		·	-	c or respiratory a	rrest,		Approximate Interval Between				
8	Physician		Immediate Cause (Final disease or condition resulting in death)		2 WEEKS										
	/Medical Examiner		resulting in death)	a. CONGESTIVE Due to (or as a consequence)	uence of):	(>				Baltimore Co. 9. Birthplace (State or Foreign Country) Pennsylvania 10d. Inside City Limits 1					
		- e	Sequentially list conditions, if any, leading to immediate	b. CORONARY A Due to (or as a consequence)	uence of):	7 DISCAS	DE			9. Birthplace (State or Foreign Country) Pennsylvania 10d. Inside City Limits 1					
	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. DIABETES							30 YEARS				
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ŗ.	that the bed by detail		Part II. Dther significant conditions of	contributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use co	ntribute lo ti	he cause of death?				
cords,	law requires that the as been signed by th 2 should be detache	eted by	STROKE, PERI	PHERM VAS	CUL	K DISE	EASE								
Ü L	The la ate has page 2	Completed						24a. Was autop perfo	psy prmed?	prior to co death?	mpletion of cause of				
II a	Phyeicien: The ribis certificate ral director, pag	Be (25. Was case referred to medical examiner?					ath (Check only o							
0	Phyei this c al dire	To	1 Yes 2 No		ER/Outpatier		4 Indianing i				(y)				
SION	ling After Tune	tlon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe	now injury occ	nited					
UNISI	or Attenter deal	ertificati	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	OB Bloom of Injury At he	ome, farm, str			28f. Location (. City or To		nber or Rura	al Route Number,				
	o the Hospitel or thin 24 hours after the Funerei Dir impletely filled in	edical Co		nysician: To the best of my kno miner: On the basis of examina											
	the the mple	Med	29b Signature and title of certifier	and manner stated.	7	29c. Licens	se number		29d. Date sign	ned (Month	Day Year)				

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JENNIFER HAYASHI

31. Date filed (Month, Day, Year)

JUN 2 4 2011

D62032

5505 HOPKINS BAYVIEW CIRCLE BALTO, MD 21224

Registrar's Signature facility

JUNE 22, 2011

20132

		•	For State Registrar	State of Ma	Ce.	rtificate of			leg. No.						
	Physicia	an	1. Decedent's Name (First, Middle, Las					Date of Deat Month	th Day 2011	3. Time of Death					
	/Medic	al	LaVane Stanford			Als City Town o	r Location of Death	June	4c. County of Death	8:10 A M					
	Examin	er	4a. Facility Name (If not institution, give Longview Nursin			Manche			Carrol1						
	Funeral Director		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April 23	Year) 9. Birth Cou	place (State or Foreign intry) iryland					
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits					
	a-f sho	ctor	MD Carrol	1	Taneyto	own				1 □Yes 2 No					
	h with the 23a or 28	al Director	10e. Street and Number 8 Church St.			10f. Zip Code 21787		1	10g. Citizen of What Cou USA	intry?					
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evantral multibe motified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent E Armed Forces? 1	0	Was Decedent of F If Yes, specify Cuba 1 ☐ Yes 2 🗓 No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Specify: b1	etc. ack					
5	72 ho	Be Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece (Give	edent's Usual Occup e kind of work done DO NOT use retired	nation during most of work	king	16b. Kind of Business/li	ndustry					
12	within ene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5-	F)	umber	a)		home imp	rovement					
д 2	il Hygi other ent, I	Se C	17. Father's Name (First, Middle, Last)		11				Maiden Surname)						
ylar	should be fi and Mental b s marked ot umatic ever	To E	Wilbur Stanely	Butler					ue Brightfu						
, Mar	and 2 sho ealth and n 27 Is ma		19a. Informant's Name/Relationship (Dawn Duppins —		19b. Maili 22	ng Address (Street 25 N. 13t	and Number or Ru h St #1B	ral Route Numbe Philad	er, City or Town, State, Z elphia, PA	19133 					
Baltimore, Maryland 21215-0036	Pages 1 annent of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 2)	Removal from State	20b. Place of Disponentery, cre	osition (Name of matory or other plac		Date	20c. Location - City or T	own, State					
Balt	permit. Departr Importa any inju		21. Signa re Funeral Service Licen	Wade, Dix	ector				omy Board timore, MD	21201					
			23a. Part 1. Boter the disease, or com- shock, otheart failure. List only	plications that caused one cause on each lin	4.	1 0		or respiratory ar	rest,	Approximate Interval Between					
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	ancreat	ic Can	cer			Chart and Boath					
2	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):										
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60,	rificate be executed in physician and as the burial-transit		resulting in death) Last	Due to (or as a	a consequence of):										
68760,	ficate physi s the t	dic		d											
P.O. Box (death cer e attendir d for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	☐ Ectopic pregnand	су		23d. Date of deli Month	ivery Day Year					
	w requires that the de s been signed by the a should be detached to	þ	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the u	underlying cause giv	ven in Part I.		obacco use contribute to res 2 □ No 3 □ Pr	14					
Records,	@ # N	Completed						24a. Was a autop perfor 1 □ Yes	nsy prior to o rmed? death?	topsy findings available completion of cause of					
Ita	ding Physician: The In. After this certificate har funeral director, page	Be C	25. Was case referred to medical examiner?				26. Place of Dea								
<u>}</u>	Physical this call directly		1 Yes 2 No		nt 2 ER/Outpatie	ent 3 DOA			dence 6 Other (Spe	cify)					
ouo	ding F h. After funera	tion:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injui (Month, Day	ry 28b. Time (<i>y, Year)</i> Injury	Wo	ryaτ rk?]Yes 2 □No	28a. Describe r	now injury occurred						
Division of Vital	I or Attending Physician: after death. Director: After this certification by the funeral director.	Certification: To	2 Accident investigation 3 Sulcide 6 Could not b 4 Homicide determined		iry - At home, farm, st c. (Specify)			28f. Location (S City or Tov	Street and Number or Ru vn, State)	ıral Route Number,					
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C			examination and/or i				cause(s) and manner as date and place, and due						
	To the Within To the	Me	29b. Signature and title of certifier	A 4	2 5	29c. Licen		1	29d. Date signed (Mont	h, Day, Year)					
			> Gracie L	Ryberg	J. O.	HOC	61201	0	6/17/11						
			30. Name and address of person who	complete cause of	eath (Item 23a) (Type	tminst	er, M	D. 2.	1157						
	Sta Registr		31. Date filed (Month Day, 2011	32. Registra	ar's Signaturant										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23b per ab g917 7-18-11 vt
State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 05:00 M 06 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Prince Georges 12738 Holiday Lane Bowie 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** Months Days Hours Min Nov 21 **19**36 Washington DC **Director** 578-44-9147 74 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Tes 2 No MD Prince Georges Bowie ŏ 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 12738 Holiday Lane 20716 USA items 2 within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ō 1 Never Married 2X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates white "natural", Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) martgage clerk real estate Be permit. Page 1 and 2 should be filed beardment of Health and Mental Hys Important: If item 27 is marked othen any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Edwin Earl Dowling Thelma Lillian Kesteron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1217 Blossom Lane; Bowie, Maryland 20715 Lisa Escobedo - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) Director 22. Name and Address of Facility State Anatomy Board at uneral envice Lice 655 W. Baltimore St; Baltimore, MD Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or imjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? rmed8 2 X No this certificate 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 💢 No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work? within 24 hours after death To the Funeral Director, A 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) mes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mn 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 756 1M 22 2011 CHE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltmine Hospital 04 Raltinus If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Date of Birth (Month, Day, **Funeral** 112M 2□ F Months Min. 219-56-Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 √Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Fords Lane items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubar, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☐ No ð 3 Widowed 4 Divorced 'natural", Completed Health and Mental Hygiene.

em 27 is marked other than "natur

other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warran 17. Father's Name (First, Middle, Last) Be Thomasine ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Koberta Fords 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Catonsville Marylan 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dec timore Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** MUDCALAIM /Medical Examiner ther oschootin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. <u>۾</u> 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? tailour 2 No 1 ☐ Yes the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ PR/Outpatient 3 ☐ DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 1 Yes 2 No Certification: To 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending Fath. 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature of title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 73 2011 Jerome J. Curtis 1340 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 1709 E. 33rd Street If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Mary land 1 M 2 D F Months Days Hours Min. April 28, 79 214-26-0263 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No N/A Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21218 USA 1709 E. 33rd Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eyer in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, ıral", or iten I Examiner ı Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: "natural", Specify: Black Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the welder Sparrows Point Shipyard 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o 1 and 2 should be fill of Health and Mental item 27 is marked ဂ္ Gertrude William Curtis, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1223 N. Gilmor Street Baltimore, Maryland 21217 Sharon Curtis - Wife permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Loudon Park Cemetery 6/25/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Road Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) outension Medical Examiner Necolasia nyaepimelial Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury ending physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a d be detached f 9 Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has Yes 2 No 1 Yes 2 No **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 124 hours after death.
Funeral Director: After the leted filled in by the funeral 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, within 24 hours after To the Funeral Direc determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Wathins, M. C. 29c. License number CMIX 06/23/2011 D0063657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 33(2 St., Ste. 136 Baltimore, MD 21218 Watkins M.D. 200 8. Craig Registrar's Signatur State back Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June Physician/ 20°11 11:00 P M Raymond Allaeys Carter Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick 2526 Station Road Middletown Year If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F July 19 Hours Min. Months 1930 Englind Director 80 192-34-1790 Usual Residence of Deceder 28a-f shov ed other than "natural", or items 23a or 28a-f shower, the Medical Examiner must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛛 No Frederick Middletown Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21769 2526 Station Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th Farrier/Horseman 12 Horse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Frank Carter Helen Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2526 Station Rd. Middletown, Patricia D. Carter / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Journey Crematory 6/24/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ METGSTATIZ disease or condition resulting in death) DIOSTATE CANCEL year Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) ending physician a burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Other (specify) the 1 ☐ Yes 2 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an the Hospital or Attending Physician: The law autopsy performed? Yes 2 No has , page 2 certificate l 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after acc.
To the Funeral Director. Aft 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

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M.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Goldstein MD

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00067691

7 44 ST

06 21-2011

Frederick MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2011 18. 11:05 A M Lily Alice Clark Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth Social Security Number **Funeral** (Month, Day, 1 M 2 XF Months Davs Hours Min 1919 Nebraska Yrs **Director** 508-05-9140 Jan Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 X No Middletown Frederick Maryland ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 8109 Old Hagerstown Road 21769 United States items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be Page 1 and 2 should be filed went of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ other traumatic Homer Holland Lena Binkholder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine A. Stone / Daughter 8109 Old Hagerstown Rd. Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot cemetery, crematory or other place. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 6/25/2011 Woodbine, Maryland Final Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ dăÿŝ Acute Cerebral Infarction disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Hypertension years Sequentially list conditions cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last Aortic Stenosis and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, Pulmonary Hypertension, Renal Failure, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Congestive Heart Failure autopsy performed After this certificate has page 2 1 ☐ Yes 2 No Division of Vital Phospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Language 1 DOA 2 DOA 2 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation completed filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Supanich RSM MD D 0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V 1500 Forest Glen Rd. Rm 727 Silver Spring, MD 20910 Barbara Supanich Registrar's Signature IUN 24 Registrar

11-04599 Michelle Crouch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 20138

	1- For State Registrar		Certifica	ate of	Death			Reg	. No.		
Physician/	Decedent's Name (First, Midd	lle,Last)					i N	ate of Death Nonth	Day Year		3. Time of Death 1520 hrs
Medical Examiner	Michelle L 4a. Facility Name (if not institution		···	I di	c. City, Town, or	I neation of		une 19, 20	11 4c. County of	Death	1520 1115
	1908 Wilkins Avenue		,	"	Baltimore	Location of	Dodui		io. County of	Dodaii	
Funeral	5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birt	hday)	If Under 1 Year	If Under	24Hrs. 8.	Date of Birth	(MM/DD/YYYY)		
Director	218-84-2851	1 M 2 F	45	Yrs.	Months Days	Hours	Min.	1/19/		Foreigr Moy	r Fyland
	Usual Residence of Decedent										
w any	10a. State 10b. County		10c. City, Town								10d. Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show 1 at ouce.	MD n/	а	Ba]	.timo	re 10f. Zip Code			110	g. Citizen of Wha	t Court	
or 28, lied at						20		100	g. Citizen of vine		
or items 23a or 28a-f sho must be notified at ouce. Funeral Director	1908 Wilkens A	12. Was Deceden	t Ever in U.S.	13. Was	2122 Decedent of His		n? (Specify	Yes or No-	14. Race -	USA Americ	an Indian, Black,
ritem	1 Never Married 2 N	Armed Forces	? No		s, specify Cuban				White,	etc.	
after of ner mer m	3 Widowed 4 Di	vorced If Yes, Give Year or Dates:	E 140	1 🗌 🐧	res 2 X No	specify:			Specify:	Whi	te
5-0036 led within 72 hours aft stygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Spe				s Usual Occupat st of working life.			done	16b. Kind of Bus	iness/In	dustry
36 in 72 thau "	Elementary/Secondary (0-12)	College (1-4 or	5+)		Homemake	- 10			11.		
d with the term of	17. Father's Name (First, Middle	e, Last)					Name (Fire	st, Middle, Ma	Home aiden Surname)		
215 be file mtal H rked o ent, th	William Gene	Anderson				Bett	ty Spa	arks			
MD 21215-0036 1. should be filed within 7 th and Mental Hygiene. 1.7 is marked other than marke event, the Medica. To Be Comple	19a. Informant's Name/Relation:								er, City or Town		
	Betty Sparks 20a. Method of Disposition	/ Mother			tafford		et l		ore, Mar 20c. Location - G		nd 21229
Baltimore, semit. Pages 1 ar Department of Hea Unportant: If ite Injury or other tr	1 Burial 2 Crematio	n 3 Removal from S		ory or othe							
Lim L. Pag Ement Trant:	4 Donation 5 Other S		Loudor		k Cemete		6/24/	/11	Baltimo	re,	Maryland
Ball permit Depar Impo	21. Signature of Funeral Service	Lice see	1		me and Address	-	Loud	lon Pa:	rk Funer e, Maryl	al	Home
Physician	23a. Part I. Enter the disease o			Approximate Interval							
/Medical	failure. List only one cause Immediate Cause (Final disease			Between Onset and Death							
Examiner	or condition resulting in death)	Due to (or as a cons									
_	Sequentially list conditions, if any, leading to immediate	b Due to (or as a cons	eanence ag.		,					-	
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	С.									l
Exa	events resulting in death) Last	Due to (or as a cons	equence of):								
	X UNPENDED		,27,28a-	f,pe	r me,g91	6 6-3	0-11	sm			
760, icate be execuphysician and the burial - tr	IF FEMALE:	23c. If yes, outco							23d. Date of d	elivery	
687 ertifice fing pl as th	23h Was decedent pregnant in t	he 1 Live birth	2	Feta	I death 3 [Ectopic	pregnancy		Month	Da	ay Year
b. Box 687 the death certific the attending inched for use as the Physician.	1 Yes 2 No 9 ✔ Ur		t time of death	Othe	er (Specify)						
that the done by the detached i	Part II. Other significant condi		th but not resulting	g in the un	derlying cause g	iven in Parl	t I.	23e. Did tob	acco use contrib	ute to ti	ne cause of death?
ires that signed to be deta								1 Yes	2 No 3	Proba	ably 4 Unknown
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eco ne law te has ige 2 s						-		perform	<u>red</u> ? de	ath?	·
Vital Rec ysician: The l his certificate I director, page	25. Was case referred to medical	al			26.Place	of Death (C	Check only				
F Vital Physician r this certi ral directo	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ent 2 ER/O	utpatient	3 DOA	Other ₄	Nursing Ho	ome 5 R	esidence 6 🗸	Other:	Scene
ing Pi After funera	27. Manner of Death 1 Natural 5 People	28a. Date of Inj (Month, Day,	ury 28b. Year)	Time of Inj	· I _ ·	y at Work?			w injury occurre	d	
Sior Attend death cctor: by the	2 Accident Inve	estigation fd 6-19		3:14	pm	′es 2X I		Unknow		ar Dua	al Route Number, City
Division of Vital Records, P.O. spital or Attending Physician: The law requires that th tours after death. Ineral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact Certification: To Be Completed by P.	3 Suicide 6 X Cou	ild not be	njury - At home, fa sidence	arm, street	, ractory, onice o	uliding, etc.			te) 1908 Ta		ens Ave.
Hospit Tuner Tuner Ely fill	4 Homicide 29a. Certifier 1 Certifying F	Physician: To the best of n		ath occurre	ed at the time, da	ite and plac				as state	d.
Division of To the Hospital or Attending Phe within 24 hours after death. To the Fruneral Director: After a completely filled in by the funeral Medical Certification: T		aminer: On the basis of exa									
F 3 F 8	29b. Signature and title of certification				29c. Licens	e number			29d. Date signe	(Mon	th, Day, Year)
	alle	M	X (O.C.I	M.E.			June 20, 20	11	
	30. Name and address of perso	- 1	/	O M D	oltimora Ctr-	oi Deli:	nore M	24222			
		Assistant Medical E	ar's Signature	U VV. D	altimore Stre	ei, baitin	nore, ML	7 2 1223			
State Registrar	11111	Bene A.	bare	/							

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 12, MARIE F. CYPHERT 2011 10:45 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FOREST HILL HEALTH & REHAB FOREST HILL HARFORD Social Security Number 8. Date of Birth DEC. 19 Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Year 19<u>21</u> Months 1 M 2 Hours Country) Director 216-14-7856 88 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. and the file and 28a or 28a-f sho and tiftem 27 is marked other than "natural", or items 23a or 28a-f sho ury or orbher traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2X No HARFORD BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1302 TURRET RD 21015 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 No Specify: If Yes, Give 3X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OFFICE WORKER RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည HENRY KAHLER BESSIE COX 19a. Informant's Name/Relationship (Type, Print) $^{19\text{b}}$. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1302\ TURRET\ RD\ BEL\ AIR,\ MD\ 21015$ PAULA ADLE-DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place
ATLANTIC CREMATORY 6/6/11 4 Donation 5 Other (Specify) GLEN BURNIE, MD 22. Name and Address of Facility SCHIMONEK FUNERAL HOME OF BEL AIR Signature of Funeral Service Licensee 610 W. MACPHAIL RD BEL AIR, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ending physician use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) atter in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the a detached for 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 1483 B 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or Attending Physician: The law autopsy C 145 performed? Director: After this certificate 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural after death 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 032215 JUNE 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

11-04643 Jammie Cherry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 | | | | | | | | |

		1- For State Registrar				Certific	cate of	Death					Reg. No).			
Physicia	in/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 1919 hrs															
ledical Exami	ner	Jammie											, 2011			1919 hrs	
		4a. Facility Name (in University H		on, give street an	id number)		41	c. City, Town Baltimore		ocation of	Death		4	c. County of	of Death		
Funeral Director		5. Social Security N 579-48-		6. Sex		e (In yrs. last bi		If Under 1	Year Days	If Under Hours	24Hrs. Min.			1/DD/YYYY 29	Foreign	nplace (State of notice) NC	r
Director				1X M 2	F	81	Yrs.					11	21	29	Cor	intry) INC	
ě.		Usual Residence of 10a. State	10b. County		-	10c. City, Tow	n or Locatio	n							1	10d. Inside Cit	y Limits
faryland 28a-f show a	ь	MD	NA	1		Ва	ltimo	re								1 X Yes 2	No
Maryla 28a-f	Director	10e. Street and Nur	nber					10f. Zip Cod	e				10g. Ci	tizen of Wh	nat Coun	try?	
with the Maryland ms 23a or 28a-f sho be notified at ooce		3425 Wa	lbrod	k Ave				2.	121	L6				U.S	5 • A •		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-fahe or other treumetic event, the Medical Examiner, must be notified at occ	unera	11. Marital Status 1 Never Marrie	ed 2 XM	arried Arme	ed Forces?	Ever in U.S.		Decedent of s, specify Cu					No-	14. Race White		an Indian, Blac	ck,
fter d	<u> </u>	3 Widowed	4 🔲 Div	orced If Yes, Given Dates:		No	1 🗌	Yes 2 X	No	specify:				Specify:	Bla	ck	
11215-0036 de filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examiner	ğ ğ	15. Decedent's Ed	ucation (Spe	cify only highest	grade com	pleted) 16a		s Usual Occu					16b.	Kind of Bu	siness/Ir	dustry	
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within giene.	Ē	12th gra		na	ι		Assem	bly V				First Middle		nera n Surname		otors	
of filed at Hyg	Be C			•											,		
21215-0036 hald be filed within 7 Mental Hygiene. marked other than c event, the Medica		Andrew 19a. Informant's Na	me/Relations	hip (Type, Print				Address (S	treet a	and Numb	er or Ru		umber, (City or Tow			
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F. Heal		20a. Method of Disp 1 X Burial 2		3 Perro	al from Sta		of Disposit	ion (Name of er place)	ceme	etery,	Ī	Date	20c.	Location -	City or 1	Town, State	
Baltimore, permit. Pages I an Department of Hes important: If iteliajury or other tr		4 Donation 5	_		rai iloili Sta	Garr	ison	Fore	st	Ve	6/	29/20	011	Owir	ngs	Mills	, MD
Balti permit. Departm Importa injury o	1	21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West															
	4	Act acc 4300 Wabash Ave, Baltimore, Md 2												21215 Approximate	Interval		
Physician /Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Sudden death following lung wedge resection												Between On: Death	set and		
Examiner		Immediate Cause (I				ath fol	lowing	g lung	we	edge	rese	ction	1		_	Deau	-
		Ecquentially list cor	villane.			lve Ath	erosci	leroti	c (Cardi	ovas	cular	Dis	sease			
	ē	if any, leading to im cause. Enter Unde	mediate		as a conse	equence of):											
	Examiner	(Disease or injury the events resulting in o	nat initiated	C.	as a conse	equence of):			_					_	-		
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760, ficate be g physical the buri	NA N	IF FEMALE: 23b. Was decedent	pregnant in t			ne of pregnanc		il death	2 [] r :			23	3d. Date of		V	
Box 68's death certifithe attending ed for use as it	cian	past 12 months		' _ '	ive birth regnant at	time of death	=	er (Specify)	3	Ectopic	pregnanc	zy .		Month	D	ay Y∈	ar
BOy e death the att	Physiciar	1 Yes 2 N	lo 9 🔲 Un	known 9 🗍 U	Inknown		Our										
P.O.	b P	Part ii. Other signif	icant condi	ions contributi	ng to death	but not resulti	ng in the un	derlying cau	se giv	en in Pari	t I.					ne cause of dea	
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Records, The law require ficate has been si, page 2 should b	Completed												opsy	р	nor to co	opsy findings a empletion of ca	
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Division al or Attendi rs after death. al Director: /	icat	2 Accident	Inve	stigation 28e	Place of Inj	ury - At home,	farm, street	, factory, offic	ce buil	Iding, etc.	. 2	8f. Location	(Street	and Number	er or Rur	al Route Numb	er, City
Diving after a filled in	E E	3 Suicide 4 Homicide		Id not be rmined (Spe						-	945	or Town	, State)				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		29a. Certifier (Check only		hysician: To the													
To the Hos within 24 h To the Fur completely	Medical				asis of exar ner stated.	nination and/or	investigatio				urred at t	he time, da					
	Σ	29b. Signature and	title of certific	er			0	29c. Lic								th, Day, Year)	
	l		004			6/21)	0.	C.M.				Jui	ne 21, 20	J I I		
		30. Name and address Russell Alex				eath (Item 23a) al Examine		V. Baltimo	ore S	treet F	Baltimo	re, MD 2	1223				
	ate				-	's Signature						, .,, .					
Regist	rar	31. Date filed (Mont	IUN 2	2011	Base	m B.	40	Man !				OCME					

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	1- Fo Regis	State trar			Certificate of Death Reg. No.										time V j ž	
Physicia Medical Examir		cedent's Name (First, M	ddle,Last)								2. Date of De Month			\Box	3. Time of Death	
	AA T	11iam	tion also	ntract and m	Thoma	as			son J		June 18,	2011			0714 hrs	
		4a. Facility Name (if not institution, give street and number) Rear of 5312 Wayne Avenue						4b. City, Town, or Location of E Baltimore				4	lc. County o	f Death		
Funeral	5. Sc	cial Security Number	6. Sex		7. Age (In	yrs. last bir	thday)	If Under 1	Year If Und	der 24Hrs.	8. Date of B	irth (MN	A/DD/YYYY)	9. Birt	hplace (State or	
Director	21	3-60-0590	1 M N	/ 2 F	_	56	Yrs.	Months E	Days Hour	s Min.	1	01	54	Foreign		
		Residence of Decedent									100	01	74			
w any	10a.	10a. State 10b. County 10c. City, Town or Location 10d. Inside City													10d. Inside City Limits	
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th the Maryland 23a or 28a-f sho notified at once.	<u>.e</u>	10e. Street and Number						10f. Zip Code					tizen of Wha	at Coun	try?	
ith the		23 Rayton					21133						U.S	. A .		
eath w items	Funeral	Never Married 2	Married	12. Was Dec Armed F	orces?		 13. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc 					0-	14. Race - White,		an Indian, Black,	
fter de l'', or		3 Widowed 4 X Divorced If Yes, Give Year						1 Yes 2 X No specify:					Specific	- 1 ס	a k	
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	2 15.	15. Decedent's Education (Specify only highest grade completed)						16a. Decedent's Usual Occupation (Give kind of work done					Specify: Black 16b. Kind of Business/Industry			
	즐ㅣ	Elementary/Secondary (0-12) College (1-4 or 5+)						during most of working life. DO NOT use retired)								
21215-0036 and be filed within 7 Mental Hygiene. marked other than cevent, the Medica	E 12	12th grade na 17. Father's Name (First, Middle, Last)					Self Employed					Self Employed				
				(7						First, Middle,					
MD 21215-003(2 should be filed within h and Mental Hygiene. 27 is marked other tha martic event, the Medic	P 19a. I	11iam T. nformant's Name/Relatio	nship (Type	e, Print)	or.	198	. Mailing A	ddress (St			ne Le			01-1-	7:0:1)	
e, MD 2121 I and 2 should be f Health and Mental Health is marker itraumatic event	Re	nee Cross	ship (Type, Print)Daughter On-Brown			er		Address (Street and Num Rayton Ro								
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imore Pages 1 nent of F tant: If i	4 =	Donation 5 Other		- Tomovar monifoldic			Site	place)		6/2	7/201	1 5	Baltimore, Md		e. Mđ	
Baltimore, permit. Pages I ar Department of He Important: If it injury or other injury or other tr	21. Si	nature of Funeral Service		22. Name and Address of Facility March F/H West				,, 202.	1 -	, arer		<u> </u>				
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Physician /Medical	23a. F	art I. Enter the disease, allure. List only one caus	e on each	line.			t enter the	mode of dyir	ng, such as c	ardiac or r	espiratory arr	est, sh	ock, or hear	t	Approximate Interval Between Onset and	
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250		entially list conditions,	b.	e to (or as a	consequen	ice or):										
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		ALE: as decedent pregnant in	the 2	23c. If yes, c		pregnancy				-		23	d. Date of de	elivery		
Sox 68 leath certifi	r pa	st 12 months?		1 Live bi	irth ant at time c	of 5	Fetal		Ectopic	pregnand	;y		Month Day Year			
Box e death c the atten ed for us	pa 1 Part II.	Yes 2 No 9 U	nknown	death Unkno		5	Other	(Specify)				1				
		Other significant cond	itions co	ntributing to	death but r	not resulting	in the und	erlying cause	given in Pa	rt I.	23e. Did to	bacco	use contribu	ite to th	e cause of death?	
S, P.(- eq							1 Yes 2 No 3 Probably 4 Vunkno				oly 4 🗸 Unknown				
ord nw req as bee	Diet							24a. Was an autopsy findings availa prior to completion of cause				psy findings available				
Rec The la	Completed by										perfor	med?	dea	th? Yes	2 No	
Cert is an	25. Wa	s case referred to medic miner?	al Hosp	ital:				26.Plac	ce of Death (Check onl	y one)					
f Vir Physic er this ral dir		✓ Yes 2 No	nosp	1 1	patient 2		tpatient 3		Other ₄	Nursing I			nce 6 🗸		Scene	
nding nding th :: Aft	1	Notural	ding		Day, Year)		ime of Injur		ury at Work?		Bd. Describe h	iow inju	iry occurred			
isicat	2	Accident Suicide 6 X Could not be Pending Investigation Suicide 6 X Could not be Pending Investigation 1 Fd 7:01 am 1 Yes 2 No Unknown Unknown 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route No. 28f. L														
Division A direction of the control	3	Suicide 6 X Cou	1ey				tate) 5	et and Number or Rural Route Number, City 5312 Wayne Ave.								
the Hospital hin 24 hours: the Fuueral npletely filled	29a. C	29d. Celuler 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated														
Division of V To the Hospital or Attending Physwithin 24 hours after death To the Funeral Director: After this completely filled in by the funeral director.	one)	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
2	29b. Si	29b. Signature and title of certifier						29c. License number				29d. Date signed (Month, Day, Year)				
		IM. CE to						O.C.M.E.				June 18, 2011				
		ne and address of person			,	,	A/ P	-								
Stat		on Locke MD. A	เธอเฮเลกโ	i iviedical	etrar's Sign		vv. Baltir	nore Stre	et, Baltim	ore, MD	21223					
Registra	Ir	e filed (Month UN Year)	4 201	1 7	ou are, Sigi	ature .	1									
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CALIVIE ZUUD													A 4	A state		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #243 at 6 2 Maryland? Department of Health and Mental Hygiens | | State Registrar Certificate of Death Rea No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 2011 2:00 AM M June 11 Medical Kenneth N. Chaney Jr 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Joseph Richey Hospice

cial Security Number 6. Sex Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Country)
Maryland 1 X M 2 □ F Days Hours 218-46-8864 Director 63 1947 June Usual Residence of Decedent or 28a-f show notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 √Yes 2 □ No MD Baltimore 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 2017 Jefferson Street 21205 USA . Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 Divorced is marked other than "natur aumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) driver transporting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ပ Kenneth N. Chaney Sr Norma Zinn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 96 Pleasant Street Newport, VT 05855 Anna Reynolds/sister permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Other Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W, Baltimore Street
Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a Examiner 10400-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami The law requires that the death certificate be executed Cause (Disease or linjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed Yes 2 After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical Division of Vital Hospital or Attending Physician: funeral director, Be 26. Place of Death (Check only one) Innatient examiner? Other: 4 Nursing Home 5 Residence 6 T Other (Specify) Hospice 1 ☐ Yes 2 🛣 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation after deat 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check зΕ only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 140067817 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State 2 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Lois Pierson Daniel June 11:47 PM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 3200 Bakers Circle I106 Frederick Adamstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days Hours Apr 3, 1926 **Director** 283-22-5013 Onio 85 Usual Residence of Decedent 28a-f show 10b. County the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Frederick Maryland Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3200 Bakers Circle I106 21710 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married 21215-0036 grene. er than "natural", o , the Medical Exam If Yes, Give 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) l other 5+ Teacher Education Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file f Health and Mental F item 27 is marked of other traumatic ever ည <u>Clyde Duvall Pierson</u> Eva Brill Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Timothy Daniel / Son</u> 607 E. Allens Ln Philadelphia, PA 19119 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 6/27/2011 Woodbine, Maryland Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metastatic Cancer - unknown primary disease or condition weeks Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) sician and burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant Month Day Vear Pregnant at time of death 5 Other (specify) 9 Unknown s been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy performed death? Yes 2 X No 1 Yes 2 No Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) Hospital ဂ္ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) D005826 6-22-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3000-D Ventrie Ct. Myerrille MD vette Warren M. D 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 5:57 PM Dill June Alvin John Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford 901 Cedar Crest Court North, Apt. Edgewood If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, 1 **X** M 2 □ F 1942 Maryland **Director** 68 214-40-8717 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10b. County with the Maryland 10a, State 10d. Inside City Limits 10c. City. Town or Location Director 1 X Yes 2 No MD Harford Edgewood 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 901 Cedar Crest Court North, Apt. 21040 U.S.A. hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify. 3 Widowed 4 X Divorced Completed Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working within 72 and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 10 Shipbuilding Sheet Metal Mechanic Be filled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve ည George Waldo Dill Elizabeth Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6714 Havenoak Road, Apt. B2, Rosedale, MD 21237 Marie Dennis / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 \square Burial 2 \square Cremation 3 \square Removal from State Anatomy Gifts Registry 4 K Donation 5 ☐ Other (Specify) 106/23/2011 Hanover, Maryland Signature of Funeral Service Lice Anatomy Gifts Registry 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ PON CIECL WNG CANCER SMACC disease or condition SHTUOM Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) 2 No be detached 9 Unknown o Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 es 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Yes director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 stesidence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural Hospital or Attending 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Editifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00028475 14535549 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATPUMEN any PHELADECPITER NOAD DALTEMAR, ND 2123T PHELEP 31. Date filed (Month, Day, Year) State **JUN 2 4** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 21. 2011 Edward Ellis Dobbs, Sr. 6:30 рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 109 Governors Court Apt A Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 D F 1938 Maryland 72 Director 216-32-5890 December 16, Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 🗆 Yes 2 🙀 No Glen Burnie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 109 Governors Court Apt A 21.061 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1X Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify:White Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City 12 Firefighter Fire Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward L. Dobbs Margaret E. Markell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Ellis Dobbs. Jr. 2914 Aspen Hill Road Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory June 23, 2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-t Physician/Medical use as yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available Was an autopsy performed? prior to completion of cause of death? 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ဂ္ 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) D504 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (orlen Burnie MD 21061 Sult 800 Sridhan Attur 7310 Ritche · Highway 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 4 2011 Registrar Acres 1 Drivin III Rev 7 2009

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marian Mary Dew Month 7:45 P Medical June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Genesis Healthcare of Hammonds Lane Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗓 F 214-14-1286 Director Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must he nother traumatic event, 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Baltimore Maryland Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4106 Annapolis Road 21227 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Unknown Read's Drug Store Unknown Sales Clerk and Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Smith Catherine Barkcowicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine B. Ward (Niece) 2318-B Tarleton Lane, Parkville, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Baltimore, Maryland 6/27/11 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signature of Funeral Service tipensee 22. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. Kevin E Ecker 237 E. Patapsco Ave., Baltimore, Md. 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death CARDIOURSCUE Pnysician/ disease or condition resulting in death) ARIBRIOSCIENDRIC Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immedicause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> DIABETES 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performed' 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 0 1 🗌 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 21776 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURYA MUNDRA MD 5021 K17 CHIE MD 21122 MUNDRA MO HIGHWAY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar SHMH 17 Hev 7/2009

11-04510 Delores Deal Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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	Registrar		Ce	rtificate d	Deam					Reg. No.			
Physician/ Medical Examiner	1. Decedent's Name (First, Midd	ta Deal							Date of De Month June 15,	Day	Year	9	3. Time of Death 1959 hrs
	4a. Facility Name (if not institution 202F Timber Trail		umber)		4b. City, Too Bel Air	vn, or Lo	ocation of	Death			County o	Death	
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of B	lirth(MM/I	DD/YYYYD		hplace (State or
Director	213-28-9750	1 M 2 F	81	Yr	Months s.	Days	Hours	Min.	June	4, 1	930	Foreig Cou	n untry)Maryland
	Usual Residence of Decedent												
Au A	10a. State 10b. County		1	, Town or Loca	ation							ı	10d. Inside City Limits
show and	Maryland Harf	ord	Be2	l Air									1 Yes 2 No
with the Maryland ms 23a or 28a-f sho be notified at once. eral Director	10e. Street and Number				10f. Zip C	ode				10g. Citiz	en of Wh	at Coun	itry?
otified Dir	202F Timber Tr	ail			210	14				USA			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Furneral Director	11. Marital Status 1 X Never Married 2 M		cedent Ever in U		as Decedent Yes, specify (lo-	14. Race · White		can Indian, Black,
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5-0036 led within 72 hours after Bygiene. other than "natural", the Medical Examiner Completed by	12	College	140101)	Secret	arv					TT.	S G	OVE	rnment
21215-0036 Jud be filed within 7 Mental Hygiene. marked other than ic event, the Medial To Be Comple	17. Father's Name (First, Middle	, Last)	·	Decire	<u>ary</u>	18	3.Mother's	Name (F	irst, Middle			010	- I Micaro
215 be file mtal Hy rked o cnt, th		DEAL					(UNK) (U	NK) (I	JNK)			
2121: nould be fil dd Mental I is marked tit event, To Be				19b. Mailir	ng Address	(Street	and Numb	ber or Rui	ral Route No	mber, Cit	ty or Towr	, State,	Zip Code)
MD 2 and 2 shou tealth and N tem 27 is n traumatic	Susan C. Paxto	n / Niece		304	Irish	Lan	e, Ak	erde	een, M	iaryl	and 2	2100)1
limore, MD Pages and 2 sh trent of Health an rent: If item 27 i	20a. Method of Disposition	•□•		Place of Dispo		of ceme	stery,	- 1	Date	20c. L	ocation -	City or	Town, State
Baltimore, permit. Pages las Department of Hei Important: If ite	1 Burial 2 Crematio 4 Demation 5 Other S		om State Hi	lltop S		Co:	rp.	6-20	-2011	To	wson	. Ma	aryland
Baltir permit. I Departme Importa	21 Signature of Funeral Service		11-		Name and A								
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Physician	23a. Part I. Enter the disease, o failure. List only one cause	r complications that o	caused the death	n. Do not enter	the mode of	dying, s	uch as ca	rdiac or r	espiratory e	rrest, sho	ck, or hea	rt	Approximate Interval Between Onset and
√Medicar ≛xaminer	Immediate Cause (Final disease	Atherseele	rotic Cardio	vascular Di	sease								Death
Zammer	or condition resulting in death)	Due to (or as	a consequence o	of):									
<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	e consequence o	of):								_	
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Box 68760, te death certificate by the attending physic for use as the burnthy sician/Mec	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes,	outcome of preg		etal death	3 [Ectopic	pregnanc	ev.		I. Date of one of the court of		ay Year
x 68	past 12 months?	4 Preg	nant at time of de	noth	other (Specifi	_		p 3	,	- 1			.,
the death cert by the attendir ched for use a	1 Yes 2 ✓ No 9 Ur	0011110											
bhat the ed by letach		tions contributing t	o death but not i	resulting in the	underlying c	ause giv	en in Par	t I.					the cause of death? ably 4 Unknown
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FVit Physic or this c	1 Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatier					Home 5				: Scene
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Division o spital or Attending tours after death. meral Director: Aft filled in by the fune Certification:	3 Suicide 6 Cou	uld not be 28e. Pla ermined (Specify	ce of Injury - At h	nome, tarm, str	eet, factory, o	mice bu	ilaing, etc	. 2	or Town,		na Numbe	rorku	ral Route Number, City
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as ledical Certification: To Be Completed by Physician		Physician: To the be	st of my knowled	dge, death occ	urred at the ti	me, date	end plac	ce, and d	ue to the ca	use(s) an	d manner	as state	ed.
To the Ho within 24 To the Fu completel	one) 2 Medical Ex	aminer: On the basis and manner	of examination a stated.	and/or investig				curred at t	he time, dat				
	29b. Signature and title of certification	ier	/	<u> </u>		License							nth, Day, Year)
	Ma		1	/	'	O.C.M	.E.			June	e 17, 20	11	
13	30. Name and address of perso Russell Alexander Mi		use of death (Iter Medical Exar) W. Baltir	nore S	Street, E	Baltimo	ore, MD 2	1223			
State	31. Date filed (Month, Day, Year,	32. F	egistrar's Signat	ture			F/ =						-
Registra	JUN 2 4 2011	Clever	p. 190	we we					UCIME				

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within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at				2 2 2 2 2 5	T						10g. Citizen o	r what Coul	ntry :
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Maryland 2 should be filed th and Mental Hy 27 is marked oth traumatic event		19a. Informant's Na	ame/Relations	hip (Type, Print)		10h Mailir	aa Addraee /Qt	treet and Numbe	er or Pura	l Paute Numbe	r City or Town	State Zin	Code
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Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral/Service I	Licensee		22	2. Name and A	Address of Facili	ty McC	omas Fi	uneral	Home,	P.A.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2011 Physician/ June ETHEL MARY DUFF-STILL 21. 8:28P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Morningside House Hanover Anne Arundel 5. Social Security Number If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday If Under 24 Hrs. 8 Date of Birth Funeral 1 M 2XXF Months Hours Min. 0*7*704*P*7913 MarvT and 216-05-0228 97 Director Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗆 Yes 2 🗶 No Maryland Anne Arundel Hanover 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? items 23a Funeral 7548 Old Telegraph Road 21076 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 6 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3XXWidowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Human Relations event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. 2 John Vincent Stein Emily Gertrude Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1503 Sycamore Street, Baltimore, Maryland 21226 Charlene A Miller DTR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery 106/30/2011 |Pikesville, Maryland □ Donation 5 □ Other (Specify) 22. Name and Address of FMitchell-Wiedefeld Funeral Home Inc ionature of Funeral 9 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or comshock, or heart failure. List only ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. nterval Between Oriset and Death Immediate Cause (Final Physician/ disease or condition * Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗌 Yes Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 1 146 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Director: After to d in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Hatural 5 Pending work 1 Tyes 2 🗌 No ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours and To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 who completed cause of death (Item 23a) (Type, Print) 32. Regis State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death . Time of Death Physician/ Month **Medical Examiner** June 15, 2011 2032 hrs Karen Faye Enfante 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3817 Hogan Lane Keedysville Washington 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs, 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director Country) Maryland 1 M 2 X F 55 1955 215-66-7987 Dec 14 Usual Residence of Decedent ıny 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 X No s 23a or 28a-f show e notified at once, 28a-f shov Keedysville hours after death with the Maryland Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ۵ 3817 Hogan Lane United States 21756 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Yes 4 X Divorced If Yes, Give Yee 1 Yes 2 X No specify: Specify: White ğ 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) t. Pages 1 and 2 should be filed within 72 l truent of Health and Mental Hygiene. rtant: If item 27 is marked other than ", or other traumatic event, the Medical I. Baltimore, MD 21215-0036 Retail Salesperson 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Leonard Bernard Pecola Barbara Jean Byars 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Pamela J. Cook / Sister 10828 Show Pony Place Damascus, MD 20872 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 6/24/2011 Woodbine, Maryland 4 Donation 5 Other Specify. 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 7:
Beverly L. Heckrotte, P.A. Clarksville, 21. Signature of Funeral Service MO1251 MD 21029 Physician 23a. Part I. Enter # disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and /Medical Death Immediate Cause (Final disease a Lung Cancer complicating Pulmonary Emphysema Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physiclan/Medical AMENDED 23a, pt.II, 27, per me, g916 6-27-11 sm X UNPENDED attending physician or use as the burial -Records, P.O. Box 68760. IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 2 Fetal death 1 Live birth 3 Ectopic pregnancy Day past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Atherosclerotic Cardivascular Disease Completed certificate has been ector, page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? ✓ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 1 V Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XX Natural 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 16, 2011 web. 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

OCME 2006

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) Registrar

32. Registrar's Signature

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	Divi	Hospital or A	al Ce		building, etc. (Specif	(y) 			City or Tow	n, State)	
		To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	(Check 2 L Medical Exam	sician: To the best of my know iner: On the basis of examination se Practioner: To the best of m	on and/or investig	ation, in my opinio	on, death occurred a	at the time, date a	nd place, and due to th	e cause(s) and manner stated.
		To the within 2 To the comple	2	29b. Signature and title of certifier	And a section of the peak of the	ry knowledge, de	29c. License	e number		29d. Date signed (Mor	
				30. Name and address of person who	completed course of death "to-	m 23a\ /Tuna P	1 4000	3095		V/23/11	
14				412 Russell Mi	vaca Bloy	500	Loch F	aver	Blud/	Baltinon	+ MO 21239
		Sta Registra		31. Date filed (MODE: 24.2011	32. Registrar / Signa	back					/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perpHYS, G916,6/24/2011, WS
State of Maryland / Department of Health and Mental Hygiene) | | | State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ OREGORG Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 32 Wagner Lane Baltimore **Essex** Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign . Age (In yrs. last birthday **Funeral** Min. 1 **X** M 2 □ F Months Days Hours Country) Michigan 65 1946 Director 07, 212-50-0921 May Usual Residence of Decedent 10b. County 10d. Inside City Limits ms 23a or 28a-f shorms must be notified at 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Tes 2 X No MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 United States 625 New Jersey Ave. items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status ı "natural", or iten edical Examiner r Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Yes, Give Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the 8 N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Fedor Stephanie Baczynski traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet F. Kermisch /Sister 4 Harwick Ct. Baltimore, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🗹 Cremation 3 🗆 Removal from State Jun 21 ö any injury once. Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2011 permit. 21. Signature of Funeral Service Licensee 22. Narcrand Address of Family Funeral Alternatives MO1585 Green Pastures Drive Towson Maryland 21286 8717 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Vear 5 Other (specify) Day Pregnant at time of death Yes been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform death? certificate 2 🗆 No Yes 2 1 Yes 25. Was case referred to dical examiner? funeral director, 26. Place of Death (Check only one) brother s Hospital: မှ 1 Tes 2 No 5 D hesidence 6 Other (Specify Residence 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home this Man of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred After Natural iniury 5 Pending s after death. Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ò 4 Homicide determined filled in within 24 hours a

To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) To the 29b. Signature and title of certifie 29c. License number Sy d address of person who completed cause of death (Item 23a) (Type Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE \mathbf{A}^{M} 2011 9:00 190 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner BALTIMORE TOWSON SAINT JOSEPH MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 - M 2 X F Min. Months Days Hours 213-38-900 Director WISCONSIN Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10b. County 10a, State 10c. City. Town or Location with the Maryland must be notified at Director 1 🗆 Yes 2 💢 No altimore 10g. Citizen of What Country? 10f. Zip Code 9 10e. Street and Numbe 23a Funeral 601 2111 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If ifew 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examiliany or other traumatic event, the Medical Examilians. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Maraverite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -Daughter Jenniter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lucius Funcial Chapta 20a. Method of Disposition . Date 20c. Location - City or Town, State 1 🗌 Burial 2 💢 Cremation 3 🗀 Removal from State June 24, 2011 Department or Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) torest Itill, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Evans Funeral Chapel + Cremation Services
16924 York Road Monkton MD 21111 Road Monkton MD 21111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 4 On Pay Seath Immediate Cause (Final RESPIRATORY FAILURE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of).
PNEUMONIA days **Examiner** Sequentially list conditions, if any hading to in modula cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical Examiner LUNG CANCER 1 YEAR and the burial-tran Due to (or as a consequence of): physician Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year for Other (specify) Pregnant at time of death signed by the a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed phonia been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 perform 1 Yes 2 No 1 ☐ Yes 2 No After this certificate 25. Was case referred to medica 26. Place of Death (Check only one) director. Be examiner? 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation the 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check The Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0059711

DHMH 17 Rev 7/2009

State Registrar 7601 OSLER DRIVE TOWSON, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

LINDA ADLER M.D.

JUN 2 4 2011

11-04523 William Everett I		igan, Sr. St 1- For State	pe or Print in ate of Maryla	and / Depa		Health a					2011	20155
Physicia Medical Exami	an/	Registrar 1. Decedent's Name (First, Midd William Evero William Evero	ett Flanis E Flanigar	gan Sr.					2. Date of D Month June 16	Day		3. Time of Death 1215 hrs
		4a. Facility Name (if not institution 3386 Garrison Circle				. City, Town, Abingdon		cation of Death		1	tc. County of Death Harford	
Funeral Director		5. Social Security Number 220–48–1534	6. Sex	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Y Months D	'ear ays	If Under 24Hrs Hours Min.	_		Foreig	hplace (State or n untry) Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Featile and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumantic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 3386 Garrison Cin 11. Marital Status 1 Never Married 2 M	ford TCle arried 12. Was Dec Armed F 1	10c. City, cedent Ever in U.sorces? 2 X No ar de completed) 1-4 or 5+) 2	Town or Location S. 13. Was If Yes 1	Decedent of some specify cut of working to the Couns of the Count of t	21 Hispaan, No spatior life. Do reet a Roocemer 2007a ess of	n (Give kind of v O NOT use retiin Mother's Name DOM IS Not not Number or F ad ESSE tery, tion 06/2	vork done (First, Middle Ary Eve Rural Route N Date 22/2011	10g. Constant of the constant	USA 14. Race - Ameri White, etc. Specify: W Kind of Business/I HOPE HOUSE In Surname)	10d. Inside City Limits 1 Yes 2 X No htry? can Indian, Black, nite ndustry Zip Code)
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Box 68760, te death certificate be execut the attending physician and red for use as the burial - tra	Physician/Medical	X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Uni Part II. Other significant conditions	23c. If yes, 1 Live t 4 Pregr	nant at time of dea	ancy 2 Fetal	death (Specify)	3 🗌	Ectopic pregna	23e. Did	I tobacc	o use contribute to	he cause of death?
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Sion of Vita Attending Physicis reath. ector: After this ce	Certification: To Be	examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pend 2 Accident Inve	28a. Date (Month		ER/Outpatient 28b. Time of Inju	28c. li	njury a	at Work?		e how ir	dence 6 Other	Scene
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To the within To the comple	Medical	one) 2 Medical Exa 29b. Signature and title of certifie Luc	and manner s		ig/or investigatio	29c. Lice		umber	t the time, da	29d	Date signed (Morne 17, 2011	
		,	int Medical Exa	miner 900 V	N. Baltimore	Street, B	altim	ore, MD 21	223			
St Regist	ate trar	31. Date filed (Month, Day, Year)	32. R	egistrar's Signatui	parke	,						

11-04533 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cei	rtificate of	Death		, g.cc F	Reg. No.	٠	
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Funeral	4	5. Social Security Number	6. Sex 7	. Age (In yrs. la	ast birthday)	If Under 1 Ye			rth(MM/DD/YYYY	9. Birth Foreign	
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arylan 8a-f si	Director	10e. Street and Number	K		Dai	10f. Zip Code			10g. Citizen of Wh		
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17215-0036 Id be filed within 72 hours after death with the Maryland Aental Hygiene. narked other than "natural", or items 23a or 28a-f abovent, the Medical Examiner must be notified at once.	ğ	15. Decedent's Education (Spe	or Dates:	completed)			ation (Give kind o	of work done	16b. Kind of Bu		
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filed all Hyg	S B	17. Father's Name (First, Middle, Andre Fenne)	•				18.Mother's Nar Debora		Maiden Surname)		
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s l and of Heal		20a. Method of Disposition 1 Surial 2 Cremation	3 Removal from		Place of Disposit rematory or other	ion (Name of c	emetery,	Date	20c. Location -	City or T	own, State
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23s-f sho injury or other traumatic event, the Medical Examiner must be notified at once	ļ	21. Signature of Funeral Service	Licensee / / / /	00.	경 생	sephoden	s of FBillows	n Jr.Fu	neral I	- Tome	PA
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n of Viding Physi	의	1 Yes 2 No 27. Manner of Death	28a. Date of	Injury I	ER/Outpatient 28b. Time of Inju		ury at Work?		Residence 6 🗸		Scene
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To t With To t	Medical	29b. Signature and title of certifier	and manner state	ed.	20.9410	29c.Licens		a. are arro, date	29d. Date signed		
		/ & calino	2110				M.E.		June 17, 20	•	
	(30. Name and address of person	who completed cause of	of death (Item 2	23a)						
			sistant Medical E			imore Stree	et, Baltimore,	MD 21223			
Stat Registra	_	31. Date filed (Month, Day, Year) JUN 2 4 2011	32. Regis	trar's Signatur	barrel						
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-		3636 Keswick Road					imore				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Funeral Director	1	5. Social Security Number	1	7. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •	If Un	ths Days	If Under Hours	0.01			Foreig	thplace (State or
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Baltimore, MD 21215-00 permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the March 1 and	Ì	21. Signature of Funeral Service Ronald	Licenses J	Trector	r 22	Name an hatm a	d Address an-Hai	of Facility	Stat	9.40ngt	omy Boa	rd	RD 21215
Physician	L,	23a. Part I. Enter the disease, or	complications that c			the mode	W. Ba	ltimo	re S	t; Bal	timore,	Mar	yland 21201 Approximate Interval
/Medical Examiner		failule List only one cause Immediate Cause (Final disease	on each line.				,			,	,,		Between Onset and Death
Examiner		or condition resulting in death)		consequence			,	_		-			
		Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	of):		_						
	틹	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a	consequence	of):								
cuted and transit	ij	events resulting in death) cast	d										
760, ficate be executed g physician and the burial - transit	Medical	UNPENDED	AMENDED										
876 tificate ng phy as the b	2	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes,	outcome of preg		etal death	n 3	Ectopic p	regnancy	,	23d. Date of Month	•) Day Year
Box 687 e death certific the attending p ed for use as th	Siciani	past 12 months? 1 Yes 2 No 9 Unk	4 Pregn	ant at time of		Other (Sp					Working		ray radi
D. BC	[-	Part II. Other significant conditi	9 Unkno	own o death but not	resulting in the	underlyin	na cause ai	en in Part		23e. Did tol	bacco use conti	ibute to	the cause of death?
P.(Asthma; Obesity				,	9 9			1 Yes			ably 4 🗸 Unknown
of Vital Records, gr Physician: The law require there is the this certificate has been sineral director, page 2 should be a consolidated.	nanaldillo									24a. Was a			topsy findings available ompletion of cause of
Reco									_	perform		death?	
ital Recieian: The section, page) B	25. Was case referred to medical examiner?	Hospital:		1			of Death (C					
n of Vi	. 1	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time of	-	DOA 28c. Injury	1	Nursing H	-	Residence 6 ow		: Scene
ion tendin eath for: A		1 Natural 5 Pend 2 Accident Inves	(Month	, Day,Year)				s 2 N			,,		
Division c spital or Attending hours after death neral Director: Af filled in by the fun	١	3 Suicide 6 Coul	d not be 28e. Plac	e of Injury - At h	nome, farm, str	eet, factor	y, office bu	ilding, etc.	28	f. Location (So		er or Ru	ral Route Number, City
Di lospital 4 hours a uneral 1		4 Homicide	rmined (Specify)										
Division To the Hospital or Attend within 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the	a l	(Check only one) 2 Medical Exam	nysician: To the bes miner:On the basis of and manner s	of examination a	age, death occi and/or investig	urred at th ation, in m	ne time, date ny opinion,	e and place death occu	e, and due rred at th	e to the cause e time, date a	e(s) and manne and place, and c	r as state due to the	ed. e cause(s)
E 3 E 3		29b. Signature and title of certifie		tateu.		29	9c. License	number			29d. Date sign	ed (Mor	nth, Day, Year)
		metz				_	O.C.M	.E.			June 18, 2	011	
		30. Name and address of person Ana Rubio MD. Ass	who completed caus istant Medical E		- ,	ltimore	Street P	altimoro	MILLS	1223			
Stat	e :	31. Date filed (Month, Day, Year)		gistrar's Signat		K	oucel, E	-	, IVIU 2	1223			
Registra		uin 2 4	11117 P.		- ////								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	Otate of Marylar		tificate of L		vicitairiy	Reg. No.	goods. Value
Physic	ian/	1. Decedent's Name (First, Middle, Las	•				2. Date of De		3. Time of Death
Med	ical	Geraldine 4a. Facility Name (if not institution, give	Goad		Ab City Town or	Location of Death	June	18 2011	
Exam	iner	Golden Years Ass			-	. Airy		4c. County of De	
Funera	-	5. Social Security Number 6. S	ex 7. Age (In yrs. II	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Date	rth 9. E	Birthplace (State or Foreign Country)
Directo	4	229-12-2868 Usual Residence of Decedent	93	115.			March :	ay, Year) (26, 1916 V	Virginia
/land f shov ed at	호	10a. State 10b. County		y, Town or Lo					10d. Inside City Limits
e Mary r 28a- notifie	jë.	MD Montg	omery		Gaithe	rsburg			1 ☐ Yes 2 🕅 No
with the s 23a o	Funeral Director	10e. Street and Number 5235 Griffith Rd	•		10f. Zip Code	20882		10g. Citizen of What United S	
death ritem iner m		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Ar Black, Wi	merican Indian,
Daltimore, IMIRTYIAID ZIZID-UU30 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once.	ed by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates.		Yes 2 No			Specify:	White
13-(Completed	15. Decedent's E (Specify only highest gr		(Give	lent's Usual Occup kind of work done o		king	16b. Kind of Busines	ss Industry
vithin jiene.		Elementary/Seconday (0-12)	College (1-4 or 5+) 5+		O NOT use retired) eacher			Education	on
filed val Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle	, Maiden Surname)	
YIZING JId be filed I Mental Hy narked ott	은	Thomas	Turner			Susant	nah	No1a	ınd
Mal 2 shorth and th and 27 is n		19a. Informant's Name/Relationship (T) Winona G. Ware /			g Address (Street a			er, City or Town, State,	Zip Code) 20882
Te, 1 and if Heal item		20a. Method of Disposition	20b. P	Place of Dispo	sition (Name of	ŀ	Date	20c. Location - City	
Dall LIMO Dermit. Page 1 Department of mportant: If i any injury or conce.		1 Burial 2 Cremation 3 4 Donation 5 Other (Special	Removal from State Che	sapeak	natory or other place Cremate	ory 06/2		ı	
Dermit permit Depar Impor any in		21. Signature of Funeral/Service Accens	1º Moo3	82 22 K	Name and Address App Fune: 33 Gist	ral and (Ave. Sil	Crematio	on Services	20910
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	ne cause on each line.	h. Do not ente	er the mode of dying	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
Physician / Medica		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of the following of the fo	ary 1	Arteny	DIFE	ase		Onset and Death
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	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	ience ot):	7	7	-		
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ificate ig phy as the	Medical	IE EEMALE.	u						
eath certifice attending p	ian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnal 1 🔲 Live Birth 2 🗎 Feta	Ideath 3		y		23d. Date of o	· ·
t the dear by the at tached fo	Physician/I	1 Yes 2 V No 9 Unknown	4 Pregnant at time of d	leath 5 ∟	Other (specify)			Month	Day Year
s that igned be de	þ	Part II. Other significant conditions co	ontributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use contribute	to the cause of death? Probably 4 🗆 Unknown
require been si should	letec						24a. Was		autopsy findings available
The law	Completed						auto perfo	psy prior to ormed? prior to death'	o completion of cause of
sician: certifica irector, p	Be	25. Was case referred to medical examiner?	Hospital:			ce of Death (Chec		20110	
Physi Physi this o	은	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 2	ER/Outpatien	t 3 DOA Othe	4 ☐ Nursing Ho		dence 6. Other (Sp.	ecity) Group hime
Attending er death. ector: After by the fune	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work'		28d. Describe i	now injury occurred	
or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		et, factory, office		28f. Location (S City or Tov	Street and Number or F vn, State)	Rural Route Number,
To the Hospital or At within 24 hours after of the Funeral Direct completed filled in by	Medical (29a. Certifier 1 Certifying Phys	sician: To the best of my knowle	edge, death o	ccured at the time,	date and place, ar	nd due to the ca	use(s) and manner as	stated.
the Ho hin 24 the Fu mplete	Med	(Check 2 Medical Exami only one) 3 Certifying Nurs	ner: On the basis of examination be Practioner: To the best of my	and/or invest	gation, in my opinion eath occurred at the	n, death occurred a time, date and place	t the time, date a	and place, and due to the cause(s) and manner a	e cause(s) and manner stated. as stated.
P # P S		29b. Signature and title of certifier &	Vanne		29c. License	number 3 0 6 4 1		29d. Date signed (Mor	1th, Day, Year) 20 20/1
Oh		30. Name and address of person who c		23a) (Type, P	rint)	and	med	K Dage	20 2011. 1 Balhme imi
Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure for Ka	1 SUCK	1-010	1740	10000	2/22
Registr	ar	IIIN 2 4 2011	Cheer p. 1	4					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 2011 9:45 pm David Henry, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number . Sex 1 ☑ M 2 ☐ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Country) New York **Funeral** 8. Date of Birth Days Hours Min. 214-44-0647 Director 64 April 30. Usual Residence of Decedent or 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c, City, Town or Location 10d. Inside City Limits Director MD N/A 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1111 Milton Avenue 21213 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🗹 No Specify: 3 Divorced Completed Black Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 12th Grade Porter Broady Management and Mental Hygie Is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) David Henry, Sr. permit, Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e Gertrude Clavon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille P. Henry - Wife 1111 Milton Avenue Baltimore, Maryland 21213 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 M Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Mount Cemetery 6/22/2011 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman Harris Funeral Home uller 4210 Belair Road Baltimore, Maryland 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one of Immediate Cause (Final Onset and Death Physician/ noctate disease or condition resulting in death) Medical ue to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): Exami and resulting in death) Last Due to (or as a consequence of): burialphysician the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a d be detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) HOSPice 1 Inpatient 2 I ER/Outpatient 3 I DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only o 29b. Signat D00712 Jan person who completed cause of death (Item 23a) (Type, Print) 6701 N. Challes St. Suite 4105, 2014 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month 2011 3:00 P M Arthur William Howe, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST AGNES HASAITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 1926 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1**X** M 2 □ F Mary Tand 85 Director 216-20-1466 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Modical Examinar must be notified at Director Baltimore Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4912 Gateway Terrace 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □XYes 2 □ No If Yes, Give 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced WW II Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Elctrical Engineer U.S. Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic event, 2008. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Arthur Howe Julia McAlister 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4912 Gateway Terrace, Baltimore, MD 21227 Theresa R. Howe (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ty☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 6/22/11 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final PRELIMENIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or injur that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MICHOSCIPIC POLY ANDITOS 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown this certificate has been HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Division of Vital 1 ☐ Yes the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: d in by the f 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. within 2 To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MEDICAL KES OBNI 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #19b Per FH G916 6/28/2011 JH
State of Maryland / Department of Health and Mental Hygien Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 4a. Facility Name (If not institution, give street and number) 06 2011 1:45pm /Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital

5. Social Security Number 6. Sex 7. Ag Baltimore Center Rosedale 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**2** M 2□ F Months Days Hours Min 216-40-2030 Usual Residence of Decedent Director June 18, 1940 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modral Evancine must be neithed at anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 □ No Baltimore Roseda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Bi Havenoak 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced White Hewitt, George 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tarm Worker terming 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Stevens Sr. မ Leorge William . Ilian 19a. Informan's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6715 Havenoak, Road, Rosedale, Maryland 21237 her 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date unk 20c. Location - City or Town, State 1 ☐ Burial 2 Z Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Allentown, PA skeen misso Cremetary 21. Signature Ineri Service Lie 22. Name and Addres - acility AM 1232 Michalley Dr. Jessey, PA 18434 23a. Rart 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease) if condition resulting in death)

a. He more than 133 Modala V. Physician Hemorrhagic Due to (or as a consequence of): /Medical Examiner Due for as a consequence of povolemia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year Day 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 500000 June 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Baltimore MD, 21237 Dr. Ahmad Alawad MD filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 17,2011 Genevieve Ann Hartman June 11:30P [™] Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Balto. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) ay 21,1935 1 M 2 XF Months Days Hours Min Director 215-30-8107 Maryland 76 May Usual Residence of Decedent or 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Md. Balto. Nottingham 1 ☐ Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20 Juliet Lane Unit 201 21236 USA items death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No and Mental Hygiene. Is marked other than "natural", or i Completed by Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: White If Yes, Give 3
Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th <u>Accounting Clerk</u> Spice Company Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ William F. Hartman Margaret B. McNeill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health a Important: If item 27 is any injury or other tra Sister 11210 Sandy Vale Road Kingsville, Md. 21087 Patricia A. Stipek 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 😾 Burial 2 □ Cremation 3 □ Removal from State JUNE 6-22-2011 4 Donation 5 Other (Specify) Parkwood Parkville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek FuneralHome 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition LUNG CANCER Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine Due to (or as a consequence of) the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last GENEVIEVE HARTMAN IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Pregnant at time of death Month Day Year 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown peen s Were autopsy findings available prior to completion of cause of 24a. Was an Director: After this certificate has autopsy performed' death? Yes 2 No 1 Yes To the Hospital or Attending Physician: pleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 👿 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending ☐ Accident☐ Suicide Investigation 1 Yes 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge. Death occurred at the time, date and place, and day to the educate and manner as stated 29b. Signature an 29d. Date signed (Month. Day, Year) 2011 of person who completed cause of death (Item 23a) (Type, Print) Q JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} 2011 Teresa Helfrich 20 Margaret June 1:47 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1609 Van Bibber Road Edgewood Harford 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Aug. 12) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** Days Hours Min. 1 □ M 2 🔀 F Months Director <u> 218-18-9180</u> 86 Auq. 1924 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2 1 No <u>Maryland</u> Harford Edgewood 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? i item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 1609 Van Bibber Road 21040 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 🛛 Widowed 4 🗆 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 6 Homemaker Own Home Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othn any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Peter J. Hock Helen (nmn) Wechelberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia J. Arthur / Daughter 1609 Van Bibber Road, Edgewood, MD 21040 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 cemetery, crematory or other place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-24-11 Dundalk, Maryland Heart of Jesus Signature of Funeral Service Licens 22. Name and Address of Facility McComas Funeral 1317 Cokesbury Home, P.A. Rd., Abingdon, Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician/ Cancer 140 disease or condition) Medical resulting in death) Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or imjury that initiated events To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 🗋 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural within 24 hours after death.

To the Funeral Director: Aft 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of pg 29d. Date signed (Month. Dav. Year) 4223 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 103 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **PATERSON** NHOL HULL June 19. 2011 6:40P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Presbyterian Home of Maryland Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 \square F Hours 1271671928 220-20-6227 MaryPand Director 82 Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Tes 2XXNo Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 120 Beech View Court 21286 USA ed other than "natural", or items event, the Medical Examiner mu 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 XX es 2 No Korea

If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Attorney Private Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ဂ Arthur Hull Margaret Paterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health a item 27 i Janet Gruehn Hull Wife 120 Beech View Court Towson, Maryland 21286 injury or other 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If ite Burial 2 XX remation 3 - Removal from State GreenMount Crematory 06/22/2011 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) nature of Funeral S 22. Name and Address of FacMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the diseal, or composations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or eause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner 2001 Sequentially list conditions, if any leading limited in the second sequentially list conditions. if any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events Examin resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural $5 \square$ Pending iniury within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 0370/6 June 20, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth M. Green, MD 6.701 N N. Charles St., Shite 4104 Daltimore, mo 21254 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John L. Hammerbacher Month 2011 June 21 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days Min. 215-16-0048 CoMaryland Director 86 88 December 26,1922 Yrs Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl notified Maryland Baltimore Timonium 1 Tes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 2525 Pot Spring Rd., L-610 21093 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 X No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. P. Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes 2 X No If Yes, Give WWII Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 consumer lending officer banking Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 0 John L. Hammerbacher Katherine Bean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Florence Hammerbacher/wife 2525 Pot Spring Rd., L-610 Timonium, MD 21093 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or otl 20c. Location - City or Town, State 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory June 23,2011 Baltimore, Maryland permit. 21. Signature of Funeral Service Licenses John O. Mitchell IV, Funeral Services of Dulaney Valley, 200 F. Padonia Rd. Timonoum, MD 21093 P.A. 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition DEMENTIA Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗀 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Yes 2 No ed by the a 9 Unknown Unknown signed by the detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available To the Hospital or Attending Physician: The law has page 2 prior to completion of cause of death?

1 Yes 2 No autopsy performe Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No Other: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death corn 29b. Signature and title 29d. Date signed (Minth, Day, Year) 2011 0 30. Name and address of pe rson who completed cause of death (Item 23a) (Type, Print) JONES, CRNP 2300 DULANEY VALLEY RD TIMONIUM, MD 21093 Back Registrar

21, 2011

JOHN HAMMERBACHER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:01 AM Medical une 201 Eacility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death outo-lof N/A timore **Funeral** . Age (In yrs. last birthday) If Under 1 If Under 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Months Hours **Director** 217-24-5775 North Carolina 81 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location Director 10d. Inside City Limits MD N/A Baltimore 1 X Yes 2 No Known as: Johnson, Mary A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3333 Spaulding Avenue USA 21215 12. Was Decedent Eyer in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Specify. Specify: Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 10th Grade Private Duty Nurse Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Monroe Williams Effie Langston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Lloyde - Daughter 3333 Spaulding Avenue Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cardens of Eternal Hope 6/23/2011 Finksburg, Maryland 21. Signature of Eurani Sirvio Livensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy į 5 Other (specify) signed by the at d be detached for Pregnant at time of death Month Day Year 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No after death.

Director: After this certificate 1 Yes or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tes Hospital 2 M No 1 Inpatient 2 PER/Outpatient 3 I DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? Investigation
6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral C To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 7/2009

State

Belie

BACTIMOREMD 2145

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20167

ene Jacobs		St 1- For State	ate of Maryla		artment of	Health	and	Menta	al Hy	giene		CONTRACTOR OF STREET	2010
Physicia	an/	Registrar 1. Decedent's Name (First, Midd)	e,Last)		-	Dodin			1:	2. Date of Deat			3. Time of Death
edical Exami		Irene Jacobs								Month June 16, 2	Day Yea	ar	1115 hrs
		4a. Facility Name (if not institution 5695 Purdue Avenue		mber)		tb. City, Tov Baltimo		ocation of	Death		4c. County	of Death	
Faval		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast hirthday)	If Under		If Under:	24Hrs	8 Date of Bird	h/MM/DD/YYY		thplace (State or
Funeral Director		218-62-2725	1 M 2 V F	5.		Months	Days	Hours	Min.	Dec. 2		Foreig	gn buntrMaryland
		Usual Residence of Decedent	I WI Z							pec. 2	, 1333	ــــــــــــــــــــــــــــــــــــــ	7,233
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Aaryland 28a-f show 1 at oece.	tor		N/A	Balt	timore					T.			1 Yes 2 No
e Mary or 28s	Director	10e. Street and Number	7	771		10f. Zip C		1239		10	og. Citizen of W		ntry?
with th	neral D	5695 Purdue Av		FI edent Everein U	.S. 13. Wa	s Decedent			1? (Spe	ecify Yes or No-			ican Indian, Black,
hours after death with the Maryland natural", or items 23a or 28a-f ah Examiner must be sotified at oece	Fune	1 Never Married 2 M	arried Armed Fo	orces?	If Y	es, specify (Cuban, I	Mexican, F	Puerto F	Rican, etc.)		e, etc.	_
ral", o	by F	_	orced If Yes, Give Year or Dates:	r		Yes 2	_				Specify:		
hours		 Decedent's Education (Spe Elementary/Secondary (0-12) 	College (1		16a. Deceden during m	t's Usual Od ost of workin					16b. Kind of Bu	isiness/	Industry
D36 thin 7, that	Completed	12th Grade		,		Lab	orer				Priva	ate	Industry
21215-0036 uld be filed within 72 Mental Hygiene. marked other than " c event, the Medical	-	17. Father's Name (First, Middle,	Last)								laiden Surname)	
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□ å å å å	7	Frances Jacobs											MD. 21218
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Baltimore, permit. Pages I ar Department of Her Important: If ite		21. Signature of Funeral Service	Licensee	-		ame and Ad			Char	tman-Harr	is Funera	al Ho	me
		23a. Part I. Enter the disease, or	toans		A21	0 Bela	ir Ro	ad Ba	ltim	ore, Mary	zland 2120)6	Approximate Interval
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kaminer		Immediate Cause (Final disease or condition resulting in death)		consequence of		CICIO	.10	oaru	LOVA	SCUIAI	DISCUSC		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mildred A. Jung Medical Tune P 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Morningside House Baltimore Parkville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov . 4 , 1917 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days 1 M 2X F Min. 213-01-2492 Hours Maryland 93 **Director** Yrs Usual Residence of Decedent items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show the Me ical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 Old Harford Road 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced white Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) At Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Howell G. Pletsch injury or other traumatic Barbara C. Kraft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel Karcher-daughter 14901 Chelsea Circle-Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Parkville,Maryland Johns Lutheran June 23,2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility any Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Rhythen Immediate Cause (Final Onset and Death Physician/ Atrial tibrilation disease or condition rapia week Medical resulting in death) Due to (or as a consequence of): **Examiner** nngestive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to vr as a consequence of 11 attending physician and for use as the burial-transit The law requires that the death certificate be executed Myponatremia Due to (or as a consequence of): resulting in death) Last 11 Physician/Medical Pertension Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ate has been signed by the atte page 2 should be detached for Day 5 Other (specify) Year Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops performed No certificate 1 Yes 2 L No To the Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) 10 6 Other (Specify) 2 1 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence after death. Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No ☐ Accident Investigation 3 🗌 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) Kamert D0065641 M·D 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUITE 1 KAMAL a. BANGORZA M.D. 2314 JOPPA RD. EAST Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Sue 2011 3:22 Deanna Kramer June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 517 Arbor Drive Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F (Month, Day, Davs Year) 1946 West Virginia Months Hours Director Jan. 216-44-2221 65 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits **Funeral Director** must be notified 1 Yes 2 No Maryland Anne Arundel Pasadena 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 517 Arbor Drive U.S.A. 21061 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 'natural", Completed 3 Widowed 4 Divorced Year or Dates White er than "natur the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) alth and Mental Hygiene.
27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 8 N/A Distillery Labeler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Joseph Richmond Rhoda Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Earl V. Kramer (Husband) 517 Arbor Drive Glen Burnie, Maryland 21061 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. Pk. 06/23/2011 Glen Burnie, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death -Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury Dan to for as a nonsection neigh-Examir Hospital or Attending Physician: The law requires that the death certificate be executed.
 Funcis after death.
 Funcial Director: After this certificate has been signed by the attending physician and eted filled in by the funcial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav Year 1 ☐ Yes 2,75 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 🗙 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 A Natural 5 Pending Accident Investigation М 1 Yes 2 No Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signa and address of persor geath (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G917 7/01/2011 JH State of Maryland / Department of Health and Mental Hygiene | |

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		•	1. Decedent's Name (First, Middle, La	st)					2. Date of D	eath Day	Year	3. Time of Death
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/lar Jid be Wents rked rtc ev	TO E		John Kaufman					Mar	garet Gr	oves		
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Division of Vital Records, all or Attending Physician: The law requires the safter cleath. It Director: After this certificate has been signed in by the funeral director, page 2 should be coming the funeral director.	Certification: To		3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At hor c. (Specify	me, farm, stre	eet, factory, office	ce	28f. Location City or T	(Street and Nur own, State)	nber or Rui	al Route Number,
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->-0			Yan J. All	de no.			D	577	21	6/	23/	1)

DR Laura L Steele

9000 FRANKLIN 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Square DR

21237

Balto md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year Mary Anna Klausmeyer 12:20 P M Medical June 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1310 Scottsdale Drive Unit M Bel Air Harford Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) 1 🗆 M 2 🔀 F 90 Baltimore, Maryland Director 213-12-6099 May 11. 1921 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director Maryland Harford Bel Air 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 1310 Scottsdale Drive Unit M 21050 United States items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò ğ 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hairdresser Cosmetology 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) P James Soul Anna Svec Maryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Klausmeyer (Son) 1310 Scottsdale Drive Unit M Bel Air, MD 21050 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of June 27, 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Evans Funeral Chapel—Bel 4 ☐ Donation 5 ☐ Other (Specify) 2011 Forest Hill, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facilit Fivans Funeral Chapel & Cremation Services—Bel Air 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or least failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ELEBROVASC Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Physician/Medical Exami Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DNGESTIVE HEART 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? after death.

Director: After this certificate 1 🗌 Yes 2 🗌 No Yes completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \(\to \) Nursing Home 5 \(\text{Residence} \) Residence 6 \(\to \) Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 05.28 M 66 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 483 Broadwater Rd. Arnold Anne Arundel Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Days Min. 1 🗆 M 2 🔏 F Hours Feb 27 Pay, Year 23 Maryland 216-14-5129 **Director** 88 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Arnold 1 🗌 Yes 2 ី No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 483 Broadwater Rd. 21012 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 X No Specify: Completed 3 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 nent of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) nurse healthcare other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Isaac Ford Helen Annie DeLaughter 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 483 Broadwater Rd; Arnold, Maryland 21012 William C. Krieger - husband 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 X Donation 5 ☐ Other (Specify) Funeral Ser Ronal 22. Name and Address of Facility State Anatomy Board Licensee S. Walle 655 W. Baltimore St; Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cau to on each line. Approximate Interval Between Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ signed by the atte in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? autopsy After this certificate 1 Yes 2 No Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗖 Natural injury work? 5 Pending Accident Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Praction of I think the cause (s) and manner stated. d at the time, date and place, and due to the causele) and mainler as state License number 2011 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) ense Huy ANNAPOLIS MOZIYOI Cenevieve CRND 31. Date filed (Month, Day, Year) Registrar's Signatur Registrar

11-04603 James B. Long Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			1- For State Registrar	•	Cert	tificate of	Death		, ,	Reg	. No.		
Phys		n/	1. Decedent's Name (First, Midd				•			Date of Death	Day Yea	,	3. Time of Death
Medical Exa	ımın	er	James 4a. Facility Name (if not institution	B.		Long	dh. Cit. Tour	n, or Location of		June 19, 20	4c. County of	(D#	1722 hrs
			14508 Homerest Roa	· -	,	1	Silver S		oi Deatti		Montgon		
Funei	ral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. las	st birthday)	If Under 1	Year If Unde	er 24Hrs. 8	B. Date of Birth	(MM/DD/YYYY	9. Birt	hplace (State or
Direct	or		220-46-4278	1X M 2 F	62	Yrs.	Months	Days Hours	Min.	Aug. 6,	1948	Foreig Cou	Washington ^{untry)} D.C.
		ļ	Usual Residence of Decedent										
ow any			10a. State 10b. County MD Mon	tgomery	10c. City, 1	Town or Locati		Sprin	œ				10d. Inside City Limits 1 Yes 2 No
yland r-f sh	t onc	흸	10e. Street and Number				10f. Zip Co		5	1100	. Citizen of Wh	ot Cour	
e Man	notified at once.	Director	14508 Homecre	c+ Pd #314			101. 210 00	20906		log			States
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-fabo	oc not		11. Marital Status	12. Was Decedent	Ever in U.S	i. 13. Wa:	s Decedent o	f Hispanic Orig		fy Yes or No-			can Indian, Black,
death r iten	Tan .	Funeral	1 XX Never Married 2 M	larried Armed Forces	? XX No	If Ye	es, specify Co	uban, Mexican,	Puerto Ric	an, etc.)	White		
after		ă.		vorced If Yes, Give Year or Dates:			71	No specify:			Specify:		ite
hours	Exam	<u>g</u>	 Decedent's Education (Spe Elementary/Secondary (0-12) 					upation (Give I life. DO NOT			6b. Kind of Bus	siness/Ir	ndustry
936 Fin 72 than	edical	Completed	Elementary/occordary (0-12)	4	··/	Self-	employ	ed Art	ist		Art		
5-0C ed wit fygien	the M	탉	17. Father's Name (First, Middle		L			18.Mother	s Name (Fi	rst, Middle, Ma	iden Surname)		
21215-00; uld be filed with Mental Hygiene marked other t	1 1	8	John		ong	4-0888490			lerie		neresa		O'Toole
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than	a tic	우	19a. Informant's Name/Relations					,			er, City or Town		
	F	ŀ	John A. Long, 20a. Method of Disposition	Jr.,M.D./Br		ace of Disposi				hesda,	MID ZV 20c. Location -	0814	
Baltimore, permit. Pages 1 a Department of He important: If ite	other traumatic		1 Burial 2 XX Cremation	_	oto cre	ematory or oth	er place)	•	06/2	2/2011			le, MD
Baltimo permit. Page Department of Important:	5	1	4 Donation 5 Other S 21. Signature of Funeral Service								Servi		
Den Den	:		Maria	2						emation er Spri			0910
Physicia			23a. Part I. Enter the disease, or failure. List only one cause	complications that caused	the death. [Do not enter th	e mode of dy	ing, such as ca	ardiac or res	spiratory arrest	, shock, or hea		Approximate Interval Between Onset and
/Medic =xamin			Immediate Cause (Final disease	a. Complications			use						Death
			or condition resulting in death)	Due to (or es a conse	equence of):								
	1	<u></u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):								
	18	티	naise Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a cons	equence of):							_	
nd uted	ransit	_	events resulting in death) Last	d.	squerioe or).								
760, icate be executed physician and	rial -	Medical	UNPENDED	AMENDED									
760, icate be	the bu		IF FEMALE: 3b. Was decedent pregnant in th	23c. If yes, outcor	ne of pregna	_	•				23d. Date of		
Box 68	for use as	Physician	past 12 months?	1 Live birth Pregnant at	time of deat	<u>, ~ ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; </u>	al death er (Specify)	3 Ectopic	pregnancy		Month	D	ay Year
BO) e death the att	la for	<u>s</u> [1 Yes 2 No 9 Uni	known 9 Unknown		о <u> —</u> Оп	er (opcony)						
hat the			Part ii. Other significant condit				nderlying cau	se given in Par	rt I.				he cause of death?
Division of Vital Records, P.O. talor Attending Physician: The law requires that the rape death. In Infractor: After this certificate has been signed by	ld be	Completed by	Hypertensive atheros	sclerotic cardiovascu	lar diseas	se							ably 4 Unknown
Cord	2 shou									24a. Was an autopsy performe	pr		opsy findings available empletion of cause of
tal Rection: The Coertificate	, page	5	<u> </u>							1 ✓ Yes 2	No 1	Yes	2 No
ician: s certi	rector	ខ្ល	25. Was case referred to medica examiner?	Hospital: 1 Inpatie	- 1 T	R/Outpatient		of Death (Check only Nursing Ho		sidence 6		0
of Vi ing Physi After this	편 F	<u>-</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day,Y		8b. Time of In		Injury at Work?			v injury occurre		Scene
on on ath.	the fur		1 Natural 5 Pend	ding	ear)		1	Yes 2	No				
ViSi or Att fter de Direct	in by	23 E		d not be 28e. Place of In	jury - At hom	ne, farm, street	, factory, offic	ce building, etc	. 28f.			or Rur	al Route Number, City
spital cours a seral J	filled in	1 L	4 Homicide deter	mined (Specify)						or Town, State			
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending	~	_ 7		hysician: To the best of my miner:On the basis of exar									
To t	com	ᇟᆫ	29b. Signature and title of certifie	and manner stated.	1			ense number			9d. Date signe		
	<u>_</u>	- ·	/2 (, ,	1	4			C.M.E.			June 20, 20		,,
104	1,		30. Name and address of person	who completed cause of d	eath (Item 23	3a)							
, ,			· ·	Assistant Medical Ex	•		altimore S	treet, Baltin	nore, MC	21223			
Rea	Stat		31. Date filed (Month, Day, Year)	32. Registra	's Stanature	backer				*			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 PM TLE WILLIE 748 Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4o. County of Death BALTIMORE KANDALLSTOWN KANDALISTON SENESIS 8. Date of Birth (Month, Day, Year) May 27, 1917 Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 1 1 M M 2 □ F North Carolina Director 238-12-6659 94 Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5107 Old Court Road Apt. 227 USA 21133 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married "natural", or ρ 1 Yes 2 No Specify: Completed 3 🗆 Widowed 4 🗆 Divorced Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Reid Avery Company Year Steelworker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Issac Little Helen Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josie B. Little - Wife 5107 Old Court Road Randallstown, Maryland 21133 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of F cemetery, crematory or other place, 1 Durial 2 Cremation 3 Removal from State Important: If 4 Donation 5 Other (Specify) 6/29/2011 Arbutus Men. Park Arbutus, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Road Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death URINAR Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Exami burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death
9 Unknown been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes Yes 2 N 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 2 No 1 Yes Other: ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manney of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d, Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A:
completed filled in by the fu ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R084191 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOSSMARSHALEE DR. EKRIDBE MO 2107S 31. Date filed (Month, Day, Year) 32. Registrar's Signature **State**

DHMH 17 Rev 7/2009

Registrar

24

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 45 AM 2011 Monika /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day Birthplace (State or Foreigr Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Funeral Months Days 1 M 2 F 215-58-214 Germany Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 1 ✓Yes 2 No Director 28a-f s Harfor berd 10g. Citizen of What Country? 10e. Street and Number ö 23a 658 2100 ane by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No 12 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event. The Medical Control 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: white 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Hair Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Brenda Aberdeen hili Spaye 20c. Location - City or Town, State 20a. Method of Disposition Date UNK 1 Burial 2 Cremation 3 Removal from State Allentown) 4 Donation 5-Other (Specify) 21. Signature Punera Service Licenses 22. Name and Address of Ea Jassup, PA 1232 Midvallex end Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between sho Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Non-ischemic ca-diamuppathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and I for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 💢 No Pregnant at time of death 5 Other (specify) 9 Unknown Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 Tyes 2 🗌 No Yes Division of Vital 26. Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be examiner? 1 ☐ Yes 2 🗶 No Hospital: 1 X Inpatient Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 24 hours after death. Funeral Director: After 5 Pending investigation Injury 1 X Natural 1 🗌 Yes 2 Accident 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (check only Medical and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number mala 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 STEVEN HSU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

1 - For Amend Items 238,27 per dr., golf peartment of Health and Mental Hygiene ()
Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:25 AM 2011 tine Medical Facility Name (if not institution, give street and number 4b. City Town, or Location of Death 4c. County of Death Examiner Balhnore Mercu If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min Apr 26, 1971 Country) Hours Director 40 217-11-7948 Usual Residence of Decedent show 10a. State 10b. County with the Maryland notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 Yes XX No Glen Burnie MD Anne Arundel 10e. Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be n Funeral USA 21060 1607 Marley Ave items ? be filed within 72 hours after death ral Hygiene.
4d other than "natural", or items event, the Medical Examiner m 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 XXMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2xx No Specify. White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Billing Heal thcare Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sarah Jane McCollum Matthew A. Dykes permit. Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1607 Marley Ave., Glen Burnie, MD 21060 Joseph League 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State Glen Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) June 20, 2011 Glen Burnie, MD 22. Name and Address of Facility
Fink Funeral Home, P.A. K. Gregor 426 Crain Hwy S., Glen Burnie, MD 21061 M01148 rart 1. Enter the diseas shock, or heart failure. ease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. 23a Part 1 Finter th Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death been signed by the a should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires i within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 🗌 No ျှ 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one 29d. Date signed (Month, Day, Year) 29b. Signa ure and title of cert D56399 true 18,2011 who completed cause of death (Item 23a) (Type, Print) 30 Name an address of perso ST. Paul ST. Baltimore, MO 21202 31. Date filed (Month, Day, Year) , Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 June 12:20 A M Jarvis Lee Moyers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 1 X M 2 D F Hours Months Min °1943 Yrs Texas Director 233-66-6628 67 Usual Residence of Decedent 28a-f shov 10b. County 10a. State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9104 LeVelle Court United States 20815 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 XNo If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Complet 15. Decedent's Education 16a. Decedent's Usual Dccupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. National Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Science Foundation Atmospheric Chemist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of ည Jarvis Colfax Moyers Frances Mae Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 short of Health a 9104 LeVelle Ct Chevy Chase, MD 20815 / Wife Joan O. Moyers 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place injury or 1 Burial 2 X Cremation 3 Removal from State Department or Important: If any Injury or 4 Depnation 5 Other (Specify) Journey Crematory 6/27/2011 Woodbine, Maryland Signature of Funeral Service Ligens Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of) Examiner Pneumothorax Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical phy: attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 X No 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No မ 1 XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death.

Director: Aft
d in by the fur 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifi Doos 6063

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Vital

Division of

Kanwaljit Nagi 1500 Forest Glen Rd. Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11-04644

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Robert McDonald 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2318 hrs **Medical Examiner** Robert Edmund McDonald June 20, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 2131 Homewood Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Foreign Days Hours Months Director 1 M 2 F 1946 Pennsylvania Yrs 218-46-7892 64 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. Count 1 Yes 2 No Anne Arundel Glen Burnie Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygier and the ment of Health and Mental Hygier has "natural", or items 23a or 28a-f shown it. If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatte event, the Medical Examiner must be notified at once Director 10g, Citizen of What Country? 10e Street and Number 10f. Zip Code 6459 Heritage Hill Drive 21061 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Maritat Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married Married 1X Yes Specify: White 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: 3 Widowed ۵ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) ltimore, MD 21215-0036 5+ Educator Education 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Be William F. McDonald Agnes Reilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rvan J. McDonald 6459 Heritage Hill Drive; Glen Burnie, MD 21061 son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 2 X Cremation 3 Removal from State 1 Burial 6/27/2011 Hilltop Service Corp. Towson, MD 4 Donation 5 Other Specify 1050 York Road 22. Name and Address of Facility 21. Signatur Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part I. Enter the disease, or complicate ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and Medical Death a Upper Gastrointestinal Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Chronic Alcohol Abuse with Cirrhosis of the Liver Sequentially list conditions if any, leading to immediate Due to for as a consequence off Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transi Sa UNPENDED AMENDED attending physician or use as the burial The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year 2 Fetal death Month Day past 12 months? Pregnant at time of death 5 signed by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ٤ 1 Yes 2 No 3 Probably 4 V Unknown Completed s been si should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has 2 sl performed? death? page Yes 2 No 1 🗸 Yes 2 No certificate To the Hospital or Attending Physician: 25. Was case referred to medical 26, Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗹 Other: Scene ER/Outpatient 3 DOA this 1 Yes After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 V Natural 1 Yes 2 No 5 Pending d in by the f 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 21, 2011 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Russell Alexander MD. Assistant Medical Examiner 32. Register's Signature State

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death **Physician** OVAM arie /Medical Çiţy, Town, or Location of Death 4c. County of Death not institution, give street and number) Examiner Linore Age (In yrs. last birthday) 78 Yrs. Year If Under 24 Hrs. 8. Date of Birth

(Month Day, Social Security 6. Sex If Under 1 Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗷 F 213-32. Director Usual Residence of Deceden 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Examinat must be notified at 1 ☐ Yes 2 🛰 o MD Funeral Director atonsville 10g. Citizen of What Country? 10e. Street and Number 908 USA Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working INE. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Health and Mental Hygiene. em 27 is marked other than other traumatic event, the M Administrator s Name (First, Middle, Maiden Surn 17. Father's Name (First, Middle Last) Be onnie ramuels KNOC ည 194! Informant's Name/Relationship (Type. Print Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other trong once. 20b. Place of Disposition (A cemetery, crematory of 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) e Funeral Services Pike 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Well /Medical Due to (or as a consequence of): Examiner umoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

Ie Funeral Director: A pletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number of person who completed cause of death (Item 23a) (Type, Print) 301 Name and address 900 MD Widms 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAILOWSILT Month JUNE 7:30 TANLEY 2011 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Trepid Road Nottingham Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) (Month, Day, Year) 1 🛛 M 2 🗆 F Months Days Hours Director 216-10-4728 93 April Maryland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Md. Baltimore Nottingham 10e Street and Number 10g. Citizen of What Country? Funeral 9617 Trepid Road 21236 USA hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2

No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. should be filed within 72 hours after of and Mental Hygiene. is marked other than "natural", or i 2 1 Never Married 2 Married If Yes, Give Year or Dates. 1941–1945 1 ☐ Yes 2 👿 No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Printing Company 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Makowski Catherine Siemek 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is n any Injury or other transpore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Makowski Son Trepid Road Nottingham, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Cher (Specify) Gardens of 6-23-2011 Faith Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc 35.0 9705 Belair Road Nottingham, Maryland 21236 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final Onset and Death Physician/ STAGE PARILINSONS DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Due to (ur as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buna Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 🖪 No 1 🗌 Yes 2 🖫 1 Tyes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a, Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check M.P. DS7722 JUNE 22

Registrar

EUNAND

Maryland 21215-0036

Baltimore,

Box (

P.O.

Records,

Division of Vital

M.D. 1838 GREENE TREE ROAD # 300 PILLESVILLE MD 21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARDSON

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARTHA MATHIS Month 7:38 P JUNE 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death N/A BALTIMORE 2608 ORLEANS ST If Under 1 Year If Under 24 Hrs. 8. Date of Birth 0011 24, 1924 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 NC 1 🗆 M 2 💢 F Days 239-36-5723 **Director** NC Usual Residence of Decedent 28a-f show 10b. b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or LOCATION Director 10d. Inside City Limits MD 1X Yes 2 □ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a (Funeral 2608 ORLEANS ST 21224 USA "natural", or items 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. WHITE permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) HOMEMAKER⁽¹⁾ College (1-4 or 5+) OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANK COSTON RUTH SIMPKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1338 GOOSE NECK RD BALTIMORE, MD 21220 ANNA ADAMS-DAUGHTER any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
HOLLY HILL Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 6/27/11 BALTIMORE, MD 4 Donation 5 Other (Specify) Scratule of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC 6224 EASTERN AVE BALTIMORE, MD 21224 23 . Part 1. Ent / the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Physician/ Onset and Death POTIA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** INFARCTION TYOCARDING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and VASCULAR that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month been signed by the should be detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 100 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 100 ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes ☐ Accident 2 🗌 No Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f, Location (Street and Number or Rural Route Number determined City or Town, State within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DENN'S H'DDLL, 9106 PH1 LADELH A 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 050 20 201 10:45a. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Himose If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🔭 F 084 213 34 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Show ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Madical Examiner is ust be notified at M∏Yes 2 ☐ No Director MD NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 801 North Fremont Ave Apt A 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married , or Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: Black ⋛ 3√ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 721 Central Laundry Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Service Presser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othany injury or other traumatic event Be Elroy McDowell Martha Lowery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janie Taylor-Daughter 3917 Woodridge Road, Baltimore, Md 21229 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 6/25/2011 Woodlawn, Md Funeral Service Licensee March F/H West 4300 Wasbash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MEIASTATU disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to for as a consecuence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 2 10 No 3 ☐ Probably 4 ☐ Unknown 1 Tes been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day, Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 No 2 Accident investigation 2011 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature an title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23at (Type, Print) UZO UNEGRUMD 283\$ SMIT 3mith AVE #203 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month e **Physician** 1950 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** Baltimore City Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 - M 2XXF Days 220-36-2799 74 26, 1937 May Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show 23a or 28a-f shoust be notified at 1 ☐ Yes 2XXNo Director Stevensville MD Queen Annes 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21666 USA 117 Whispering Pine Court must Funeral ural", or items 2 Examiner mus Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes XXNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XX No White 2 Specify. 3₩Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical (Specify only highest grade completed, I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental I is marked Nellie Rossiter Leisner ,0 Clarence traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health ant: If item 27 i Stevensville, MD 21666 Mr. Alan Morsell / Son 117 Whispering Pine Court other i 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State ò permit. Pag Department Important: I 6/27/2011 Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation mell Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 M01479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) er **Physician**)/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). law requires that the death certificate be executed physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical as IF FEMALE nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, pe 2 1 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed' certificate or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 . No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 2 ER/Outpatient 3 🗆 DOA 6 Other (Specify) မ this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation After 1 Natural (Month, Day Year) death. M 1 ☐ Yes 2 ☐ No 2 Accident in by the after deat Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature

IDV

State Registrar

DHMH 17 Rev 1/2001

Date filed (Month, Day, Year)

Server A. Aarks

pleted cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

June 21,201

ODICINIAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 22° June 2011 12:15 PM Jean Bolen Naas Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 14809 Penfield Circle #310 Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Hours Min. July 30 New Jersey Director 031-22-8067 81 1929 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County the Maryland 10c. City. Town or Location Director 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 14809 Penfield Circle United States 20906 death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. ò 1 Never Married 2 Married 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 is marked other than "natural", or other traumatic event, the Medical Examin Completed by 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify. White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Isabel Edwards Carl Horace Bolen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Naas / Husband 14809 Penfield Circle #310 Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) fer in 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once. 4 Domation 5 Other (Specify) Journey Crematory 6/25/2011 Woodbine, Maryland Signature of Funeral Service Lic Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) sician and burial-trans resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day signed by the a Yes 2 X No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe (Records, Completed 1 X Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available 24a. Was an page 2 s autopsy performed? prior to completion of cause of death? 2 🗌 No 1 Yes l or Attending Physician: after death. Director: After this certific of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural injury 5 Pending Division 1 Yes 2 No Investigation M Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year) D23556 June 23, 2011 30. Name and address of person who completed cause of death (berr 23a) (Type, Print) Robert H. Blee 5530 Wisconsin Ave Ste. 1400 Chevy Chase, MD 20815 31. Date filed (Month, Day, Year)
JUN 2 4 2011 State racke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 2. Date of Death nt's Name (First, Middle, Last) Time of Death **Physician** /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Johns Hopkins Bayview Medical Center Baltimore 8. Date of Birth (Month, Day, Sept 12, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min 1920 1 □ M 2 🗸 F 228-16-0525 90 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 United States of America 1533 1/2 Charlotte Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No ģ Specify: 3 Nidowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Edward Hundley Callie Amanda Hickson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brenda J. Akin Daughter 120 Downs Dr. Wilmington, DE 19807 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 5 Other (Specify) Hilltop Service Corp. June 20, 2011 Towson, Maryland eral Service License 21. Signature of ²Duda²Ruck^dFüherat^{hy}Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, MD 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28a 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

• Funeral Director: A pletely filled in by the fi 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number

State Registrar Name and address

iled (Month, Day,

DHMH 17 Rev 1/2001

10

Avenue Baltimore

rson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Month Physician/ 4:20 ам Eneth H. Penn June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Future Care Lochern Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** · Virginia 1 XM 2 □ F Months Days Hours Min. (Month, Day, Yea **Director** W March 1936 059-30-6974 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 No Maryland | N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? #ms 23a or r must be r ò 10e. Street and Number Funeral 3802 Greenspring Avenue 21211 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. nan "natural", or iter Medical Examiner Armed Force Black, White, etc. ☐ Never Married 2 ☐ Married ģ 2 No Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 □ Divorced If Yes, Give Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Unk. Construction Worker Private Industry event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ρ other traumatic Ed Lee Motlley Henrietta Hancock Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 3802 Greenspring Avenue Baltimore, MD 21211 Carlton Penn/Son Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 6/23/2011 Baltimore, MD 4 Donation 5 Other (Specify) Greenmount Cemeterv 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Freeral Service Lice tuis 5240 Reisterstown Road Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami physician and s the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available 24a. Was an page 2 s autopsy prior to completion of cause of death? 1 Yes 25 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I Division of Vital 25. Was case referred to nedical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural work? 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one and title of certifier 29b. Signatu 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

North World (Sharam 8813) Warth 9 m World Day Registrar's State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 9:45 A Anne Balderston Peery Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Airy 13307 Penn Shop Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Days Hours Min (Month, Day Year) Sept 25, Pennsylvania Yrs 1947 Director 161-40-2639 63 Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ier must be notified 1 XYes 2 No Jefferson City MO Cole 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 1603 Jefferson Heights Drive #D 65109 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 6 ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: White "natural" Completed 3 Widowed 4 X Divorced Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Department of life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Specialist Natural Resources 4 Environmental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Mary Evelyn Kirk William Balderston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13307 Penn Shop Ct. Mt. Airy, Emerson Peerv 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Woodbine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 6/21/2011 21. Signat of Funeral Service Lic Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate
For a mortying
Cause (Disease or iinjury Due to (or as a consequence of): ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ģ Pregnant at time of death Other (specify) detached 9 Unknown a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed I þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 performed? Yes 2 Ao death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? son's Hospital 2 **X**0No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of De h Natural 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 1 🕮 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only one) 29b. Signature and title of icense number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 16 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® (1) For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June Dale Poland 2011 11:49P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Dundalk 1302 Blakewood Court If Under 24 Hrs. Hours Min. Social Security Number If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 F Months Days (Month, Day, Y March 4 Year Director Maryland 79 1932 215-26-6911 Usual Residence of Decedent la or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Dunda1k 1 Yes 2X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ral", or items 23a Examiner must b 1302 Blakewood Court United States 21222 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muore. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: Specify: Completed 3 Widowed 4 Divorced White 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General Motors Corp. Assembly Line Worker 8 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lulu Foutz John Poland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 1302 Blakewood Court Dundalk, Maryland 21222 Nora V. Poland (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/25/2011 Baltimore, Maryland Oak Lawn Cemetery ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Lice Bulda-Ricks Funeral Home of Dundalk, Inc. 21. Sign 7922 Wise Ave. Dundalk, Maryland Inter the disease, or complications that caused the death. Do not enter the man e of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each nterval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** VOL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events -tran and resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2¹ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital 2 🔀 No Other: 1 🗌 Yes မ this 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 XNatural 5 Pendina M 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number
D 2G 43 29b. Signature and title p 29d, Date signer (Month, Day, Year) 23 21091 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DHMH 17 Rev 7/2009

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Charles	Palmer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Division of Vital B Division of Attending Physician: within 24 hours after death.			29a. Certifier , (Check only one)	1 Certifyii	ng Phys Examir	ician: To th	e best of my lasis of exami	knowledge, death nation and/or inve	occurred at t estigation, in	my opin	ion, death	occurred a	t the time, o	tate and	place, and du	ue to th	ne cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:39 AM M 2011 June 16, Dorothy E. Pyles /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 8542 Willow Oak Road Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug 5, 1924 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F 86 Massachusetts 028-12-7141 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
Inst: If item 27 is marked other than "natural", or items 23a or 28a-f show mit; If item 27 is marked other than "natural", or other than any or other than any or other than any or other than any or other than any or other than any or other than any or other than any or other than any or other than any or other than any or other than any or other than any or other than any or other than any or other than any or other than any or other than any other than any or other than any or other than any other than any other than any or other than any other tha 1 ☐ Yes 2 No **Funeral Director** Parkville Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21234 8542 Willow Oak Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 戶 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify ģ 3 ₩idowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) office work 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Ellen Sullivan George Robert Alcott ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 5113 Braeburn Way; Perry Hall, Maryland 21128 Kenneth Pyles - son Department of Health Important: If item 27 any Injury or other tr Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☑ Donation 5 ☐ Other (Specify) 22. Name, and Address of Facility State Anatomy Board 21. Signature Funeral 3 ryice Licensee 1 and S. Wada, Director 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Ca (Final disease or condition resulting in death) Chronic Physician YEAVS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Hyperuricemia burial-trar Due to or as a consequence of): Box 68760. the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. ned by the a s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 1 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To 28b. Time of Injury 27. Manger of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division of Vital Records, within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Box 19099, Towson, MD 21284 Alexander 31. Date filed (Month, Day, Year) Registrar's Signa State Registrar

1016

(Check only one)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROMMEL Month E John WILLIAM 18:05 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY of MARYLAND CENTER MEDILA BAZTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🗚 2 🗆 F Months Hours 06/01/1939 MARYLAND 212 34 0527 72 Yrs. Director Usual Residence of Decedent 28a-f shov 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Maryland in the 27 is marked other than "natural", or items 23a or 28a-f shor ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD BALTIMORE ROSEDALE 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2038 WINTERGREEN PLACE 21237 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE If Yes, Give Year or Dates 1 Yes 2X No Specify. Completed 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) STAFF REP STEELWORKERS Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ WILLIAM BARRY CATHERINE MYERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARLENE ROMMEL/WIFE 2038 WINTERGREEN PLACE BALTIMORE, MD 21237 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place, METRO CREMATORY 6/23/11 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Deensee MD 21237 1211 CHESACO AVE BALTIMORE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Ventelator associated NEUMONTE Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list over thems Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): s been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

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To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and itle of certifier 29c. License number 29d, Date signed (Month, Day, Year, 2 P24346 KOLTZ, MD JUNE 19, 2011 VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/201 CENTER 5 GREENE ST RATIMORE, ND UNIVERSITY of 22 MARYLANS JANIEM 31. Date filed (Month) Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month $6-22^{-2}$ 12:55PM M Nancy Μ. Reynolds Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Georges 2805 Bosworth Lane Bowie If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Country) W. Va. 1 □ M 2 🕱 F Months Days Hours Min. Director 232-42-5891 Usual Residence of Decedent 28a-f show 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges Bowie 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2805 Bosworth 20715 by Funeral Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: 3 → Widowed 4 □ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last)
Earl Moore Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Juanita L1ng 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 11414 Cove Court Rd. Berlin, Maryland 21811 Sandra Reynolds 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-24-2011 Atlantic Crematory Glen Burnie, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home South 16000 Annapolis Road Bowie, Md. 20715 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastic disease or condition LARGINON Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Year Day Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, icate has been sig ; page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 No Yes 2 No 1 Yes Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospital of within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

Center

Suite

Dave,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HERITH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1^D8 2011 12:52 AM David Lee Ross Medical 4a. Facility Name (if not institution, give street and number)
405 Philadelphia Ave, Apt. 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ocean City Worcester n yrs. last birthday) 5. Social Security Number 6. Sex 1 ★ M 2 □ F If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min. Maryland Hours 11 MM 29 19963 Director 220-84-7509 Usual Residence of Decedent show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 405 Philadelphia Ave., Apt. 21842 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: Completed 3 Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture 12 Farmer Be 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Mitchell / Companion Philadelphia Ave., Apt. 16. Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🗆 Removal from State Anatomy Gifts Registry 06/20/2011 4 X Donation 5 Other (Specify) |Hanover, Maryland 21. Signatur of Funeral Service 22. Name and Address of Facility Anatomy Gifts Registry ensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ 0 disease or condition Medical resulting in death) Due to (or a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): Exami Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) Yes 2 No the a 9 Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 1 ☐ Unknown Hospital or Attending Physician: The law requires cate has been siç ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' this certificate h 1 Yes 2 No Yes 2V 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \text{Nursing Home} \) Residence 6 \(\triangle \text{Other} \) Other (Specify) No No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 🖺 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year) D 63199 6/18/11

State Registrar YOGESH

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

EASTERN SHORE

DR

SA USBURY

21804

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print

VO HRA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2011 Elizabeth Rhodes 2:12 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Timonium 102 Greenmeadow Drive Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** April Day Year 1930 1 □ M 2 🗓 F 218-26-7991 Marvland 81 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 102 Greenmeadow Drive 21093 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Burns Beehler Gladys Joseph Μ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Plymouth, NH 03264 211 Reservoir Road f Health item 27 Stephen Rhodes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or otl 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Hilltop Service Corp. 6-24-2011 Maryland Towson 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Funer | Service bi Insee Towson, Maryland 21204 1050 York Road Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the disease, or complica Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be emiliable tours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year 1 Yes 2 P Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ᅆ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 1 Yes 2 \square No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

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State Registrar npleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan Physician/ 1:30 PM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sound Raven Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Baltimore, Maryland Days Hours (Month, Day, 1 □ M 2**X** F 98 213-16-4035 Director January 09,1913 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State Director Nottingham 1 Yes 2 X No Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 21236 46 Jumpers Circle 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Page 1 and 2 should be filed within 72 hours aftiment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", ury or other traumatic event, the Medical Exau ury or other traumatic event, the Medical 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Factory Silver Polisher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Christina Gas ည Aloysuis Schisler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 46 Jumpers Circle Nottingham, Maryland 21236 Helen Tucker (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s Department of H Important: If ite 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkville, Maryland injury Moreland Memorial Park June 25, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

23a. Part 1. Enter the disease, or complications that caused shock, or lear failure. List only one cause on each line. Immediate Cause (Final disease or condition assets) 22. Name and Address of Facility
Evans Fineral Chapel & Cremation Services—Parkville Parkville, Maryland 21 8800 Harford Road Approximate Interval Between or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, O et and Death Jepsis Physician/ days Medical resulting in death) s a consequence of): Due to (or Examiner au neumonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innertal director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Fctonic pregnancy in the past 12 months? Month Day 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Médical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) son who ompleted cause of death (Item 23a) (Type, Print) Drive Elkridge Md. 21075

State Registrar

aver 31. Date filed (Month, Day, Year) 6095 Marsh

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year James Robinson Jr. Medical 06 2011 3:15a 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Joseph Richey Hospice Baltimore Social Security Number Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Min (Month, Day, Year) 250-58-7525 73 Director 01Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 3010 West Mosher Street 21216 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No er than "natural", or ite Black, White, etc. ģ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Limo Driver 8th grade United Health na permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill thent of Health and Mental rant: If item 27 is marked o James Robinson Sr. Marie Joe 19a. Informant's Name/Relationship (Type, Print) ح 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\ 21216$ Emma Robinson-Wife 3010 West Mosher Street, Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) 6/28/2011 Baltimore, Md Zion 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 4300 Wabash Av ala Baltimore, 21215 Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death metas tetiz tol Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1111 0 Sequentially list conditions, if any leading to immediate cause. Enter Underlying by Physician/Medical Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last or Attending Physician: The law requires that the death certificate be IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ P.O. Box in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed? death? 1 ☐ Yes 2 🗷 No Yes 2 A No Division of Vital 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🔯 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) and title of certifie 29c. License number 0032446 29b. Signatur 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 80 HOY KINS SOHN 31. Date filed (Month, Day, 32. Registrar' Signat State 2 Registrar

E

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #16a Per FH C016 6/30/2011 III State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBINSON **BETTY** WILMAS 2011 2:56P 19 June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist 9. Birthplace (State or Foreign Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday, **Funeral** 1 M 2 X XF Hours 0197574927 291-22-3441 84 Missouri Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 🗆 Yes 💥 No Baltimore Towson Maryland 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 21286 USA 800 Southerly Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status ?7 is marked other than "natural", or iter traumatic event, the Medical Examiner Armed Forces 1

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify Specify 3 XXWidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Psychiatrist College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Phychiatrist Medical and Mental Hygien is marked other tl Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic ever ပ Carl Julius Wilmas Iva Lee Richards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10544 Faulkner Ridge Circle Columbia Maryland 21044 **DTR** Jill R Robinson 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date GreenMount Crematory 06/27/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) ignature of Funeral Ser 22. Name and Address of FaMytchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cor **Examiner** Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) physician and s the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending p IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 W6

9 Unknown Day Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certificate: To Be Completed by

Box 68760[°] P.O. Records, Division of Vital the Hospital or Attending Physician: To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu

Maryland 21215-0036

Baltimore,

		1 Yes 2 No 3 Probably 4 Winknown			
		24a. Was an autopsy performed? 1 \(\sum \) Yes 2 \(\sum \) \(\text{No} \) 1 \(\sum \) Yes 2 \(\sum \) \(\text{No} \) No			
25. Was case referred to medical	26. Place of Death (Check or	nly one)			
examiner? 1 Yes 2 1	Hospital: 1	ne 5 Residence 6 Dother (Specify)			
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury work? M 1 Yes 2 No	Describe how injury occurred			
3 Suicide 6 Could not b	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street and Number or Rural Route Number, City or Town, State)			
	sician: To the best of my knowledge, death occured at the time, date and place, and o ner: On the basis of examination and/or investigation, in my opinion, death occurred at the				

🗇 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

71040

29d. Date signed (Month, Day, Year)

MD

21200

BALTLMORE

State Registrar

of person who completed cause of death (Item 23a) (Type, Print) SUITE 4105 was

29b. Signature and litle of certifier

JUN 2 4 2011

backs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 8:00 P M June William Sutton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 561 Rich Mar Street Westminster 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Jan 3, Year 1928 Hours New Jersey **Director** 83 320-24-1110 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 XYes 2 No Westminster Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 561 Rich Mar Street 21158 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian "natural", or ite If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 XMarried Completed by 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than ' Elementary/Seconday (0-12) College (1-4 or 5+) ith and Mental Hygien 27 is marked other the r traumatic event, the Farming Farmer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lillian Russell Hildebrant Ross Joshua Sutton, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 561 Rich Mar St Westminster, MD 21158 Shirley M. Sutton / Wife Department of Healt Important: If item 2 any injury or other t other altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Journey Crematory 6/27/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland Flinal 21. Signature Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine physician and the burial-transit that initiated events Due to or as a consequence of resulting in death) Last Completed by Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 📉 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of e Hospital or Attending P 124 hours after death. e Funeral Director: After t leted filled in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours a Funeral L Medical 29a. Certifier 🖫 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 29c License number

P.O.

State Registrar

30. Name

DHMH 17 Rev 7/2009

d address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene U

1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 22, 2011 5:30 A M Jose Maria Sorto Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Silver Spring Montgomery 2140 Harlequin Terrace If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Hours Apr 10, ^{Yea}(⁾929 El°Sälvador **Director** 226-31-4722 82 Usual Residence of Decedent 28a-f show 10a. State 10h. County with the Maryland items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Silver Spring Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral El Salvador 20904 2140 Harlequin Terrace filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. r than "natural", or ite the Medical Examiner 1 Never Married 2 X Married ģ ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Completed 3 Widowed 4 Divorced Latino Year or Dates Salvadorian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Mechanic Transportation other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Page 1 and 2 should be Arcadia (unk) (unk) Sorto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Daughter 2140 Harlequin Terr Silver Spring, MD 20904 Ana Leti 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ò 1

Burial 2

Cremation 3

Removal from State cemetery, crematory or other place Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 6/27/2011 Woodbine, Maryland Sign we of Funeral Service Licer Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death
Years Immediate Cause (Final Ph_sician/ a. <u>Myelodysplas</u>ia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Box 68760 attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Dav 1 Yes 2 No g Unknown P.O. I signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Tes ျ After this of funeral direction 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pendina work' Accident 1 Yes 2 No neral Director: A Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D51616 June 22, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nelson Kalil 5454 Wisconsin Ave #1300 Chevy Chase, MD 20815 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item# 29d per fh g916 6-28-11 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2421 Ridgely Street Baltimore N/A Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Days Hours Min. Sept. 3, 1941 220-36-7792 69 South Carolina Director Yrs. Usual Residence of Decedent 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f MD N/A 1 Yes 2 No Baltimore 10e. Street and Number ò 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 2421 Ridgely Street 21230 USA items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes, 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any Injury or other traumatic event, the N 9th Grade Laborer Carr Lowery Glass Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Brown Virginia Mae Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosewitha O. Scott-Thomas - Daughter 3009 Mallview Road Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 MBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 6/27/2011 King Memorial Park Woodlawn, Maryland 22. Name and Address of Facility Signature of Fundamental entire Licensee Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215 art 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi). Examir burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year signed by the at d be detached for Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? Yes 2 No Director: After this certificate 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify Natural Accid funeral 27. Manner of De 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicid hours after death. filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) within 24 hours a

To the Funeral I

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Registrar DHMH 17 Rev 7/2009

State

(Check

31. Date filed (Month, Day,

3

Year

erson who completed cause of death (Item

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Christian Charles Smith 2011 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Ye
0/3/11 5. Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) 1 **X**M 2 □ F Maryland n/a 0 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Talbot Oxford 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code USA 21654 26968 Oxford Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎮 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. 1 ≥ Never Married 2 Married 1 ☐ Yes 2 No Specify If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 0 n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Angelique Perkins Christopher Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angelique Perkins / Mother 26968 Oxford Rd. Oxford, Maryland 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of Da Lanelle) Tomaton College Vision (Name of Da Lanelle) 1 Burial 2 Cremation 3 Removal from State 6/24/2011 Baltimore, Maryland @ Loudon Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ricens 22. Name and Address of Facility Loudon Park Funeral Home Baltimore, Maryland 21229 -ce 3620 Wilkens Ave. 23a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Encephalopally Immediate Cause (Final Eschen POXIC disease or condition resulting in death) Due to (dr as a consequence of): Distress Ta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)

Physician /Medical Examiner

Physician /Medical

Examiner

10a State

MD

Director

Funeral

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Director

iral", or items 23a or 28a-f shov Examiner must be notified at

"natural".

and Mental Hygiene.

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau

the Medical

or other traumatic event,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

physician and as the burial-trans as

The law requires that the death certificate be executed

Hospital or Attending Physician:

nin 24 hours after death.

the Funeral Director: After this

mpletely filled in by the funeral

Division of Vital Records, P.O. Box 68760,

edical Exami	Cause (Dis that initiate resulting in
nysician/M	IF FEMALE 23b. Was d in the 1 \sum Ye 9 \subseteq U
Completed by Phy	Part II. Other
lo Be	25. Was car examine 1 \(\subseteq Yes
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Physician,	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1	death 3 Ectopic			23d. Date of delivery Month Day Year					
by PI	Part II. Other significant conditions		ulting in the underlyin	g cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?					
	Meconium	Aspiration	1 Synd.	rome	1 ☐ Yes	2 No 3 Probably 4 Unknown					
Completed	Peis, stent	Persistent Pelmonary Hypertension of No 24a. Was an autopsy performed by yes 2									
Be	25. Was case referred to medical examiner?	I Iit-li	26. Place of Death (Check only one)								
ပ	1 🗆 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 🗆 🛭	OOA Other: 4 Nursing I	Home 5 Residence	e 5 🗆 Residence 6 🗀 Other (Specify)					
	27. Maprier of Death Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year)									
Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			ory, office	28f. Location (Stree City or Town, St	n (Street and Number or Rural Route Number, Town, State)					
Medical C			sician: To the best of my knowledge, death occurred at the time, date and place, and due to the causer. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.								
Me	29b. Signature and title of certifier	71- Joros MI	\	9c. License number	,	Date signed (Month, Day, Year)					

Registrar

31. Date filed (Month, Day, Year) JUN 2 4 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

June 20,2011

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #185 Per of Maryland 6/28/2011 of Health and Mental Hygiene

		For State Registrar	Oldio of Wil	ai yiaira		tificate of E		vicinairiy	Reg. No.			
Physicia	in/	1. Decedent's Name (First, Middle	, Last)					2. Date of De		Year	3. Time of Death	
Medic	cal	Eleanor K. S 4a. Facility Name (if not institution,				# O: T		June 2			3:45A. ^M	
Examin	er	Quail Run Assi	· -	Rm	214	4b. City, Town, or Pa	rkville	ı	4c. Co	ounty of Death Ba	lto.	
Funeral		5. Social Security Number		e (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		9. Birthpi	lace (State or Foreign	
Director		218-18-9976 1 M 2 M F 86 Yrs. Months Days Hours Min. (Month, Day, Year) County Count										
fand show dat	tor	10a. State 10b. County		10c. City, 7	Town or Loc					. 10	Od. Inside City Limits	
Mary 28a-1 notifie	Director		Balto.		Par	kville					1 Yes 2 No	
vith the 23a or st be r	ral	10e. Street and Number Quail Run Assi Walther B	sted Living	214		10f. Zip Code 21234			10g. Citize	n of What Count	try?	
leath v	Funeral	11. Marital Status	12. Was Decedent E		13. W	/as Decedent of His Yes, specify Cubar		ecify Yes or No-		. Race - America	an Indian,	
urs after d ural", or i Il Examin	<u>م</u>	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	100 2 122	No		Yes, specify Cubar Yes 2 X No		Rican, etc.)		Black, White, e ecify:	tc. Vhite	
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within giene. er tha		Elementary/Seconday (0-12) 8th	College (1-4 or 5	+)		NOT use retired) ory Worke	r		West	tern Ele	ectric	
e filed ital Hy ed oth event	To Be	17. Father's Name (First, Middle, L	ast)				18. Mother's Nan		Maiden Sur	rname)		
d Men marke martic	-	James Komin 19a. Informant's Name/Relationsh	nin (Tuno Duint)				Mary			Be1sky		
and 2 sho lealth an em 27 is her trau		Bernard Staab		on	12	g Address (Street a. Perhall	nd Number or Rur Court	al Route Numbe No	r, City or Tou ttingl	nam, Md.	21236	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		cem	lens c	ition (Name of atory or other place of Faith	6-25	Date -2011	Balt	tion - City or Tov	vn, State	
permit Depart Impor any in		21. Signature of Funeral Service L Buen & (icensee		22.	Name and Address 9705 Be1	-			alHome n, Md. 2	21236	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
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eath certi	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 4 Pregnant at	2 🗌 Fetal di	eath 3 🗌	Ectopic pregnancy Other (specify)	/		230	d. Date of deliver Month	y Day Year	
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ires that signed t d be det	2	Part II. Other significant condition	ns contributing to death bu	ut not resulti	ng in the un	derlying cause give	en in Part I.			contribute to the	e cause of death?	
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death. ctor: After y the funer	licate	1 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investig	g <i>(Month, Day,</i> jation	Year)	injury	work?		Zou. Describe n	ow injury oc	curred		
al or Attending Physician: The law requires that the death cert after death. I Director: After this certificate has been signed by the attendit in by the funeral director, page 2 should be detached for use	Certificate:	3 Suicide 6 Could n 4 Homicide determin			, farm, stree	et, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
To the Hospital or a within 24 hours after To the Funeral Dire completed filled in E	Medical	(Check 2 \square Medical Ex	Physician: To the best of n	amination an	d/or investig	ation, in my opinion	 death occurred a 	t the time date a	nd place and	d due to the caus	e(s) and manner stated	
To the within To the		29b. Signature and title of certifier	Nurse Practioner: To the b	A.	A A A	29c. License				igned (Month, Da		
1.0	-	30 Name and address of person w	yho completed source of de	eth (tam 20	9) (Time 5:	<u> 12</u>	1188		6-2	1-11		
U		/)	c Julle 2	L Ma	Mol.	Place	Duno	lauc 1	40	2122	2	
State Registra		31. Date filed (N2nt/4 2011)	32. Registrer	r's Signature	Kal							

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 3:00 A M June 21 Florence Emma Spealman Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford 2501 Willoughby Beach Road Edgewood 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5 Social Security Number **Funeral** Min. Hours Feb. 6, 1922 Marvland 89 **Director** 217-12-5283 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at Director notified 1 🗆 Yes 2 🖹 No Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral USA 21040 2501 Willoughby Beach Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. the Medical Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc ò þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Public School Cafeteria Attendant 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Menta Important: If item 27 is marked any injury or other traumating once. and Mental is marked o ည Rosa Marie Coulter Frederick William Gunther 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3244 B Conowingo Road, Street, Maryland 21154 August W. Spealman / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Air Memorial Gdn 6-25-2011 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine -tran burialattending physician for use as the buria Physician/Medical $f \alpha \chi + M \xi$ Box 68760 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 1 Yes 2 L 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? 2 1 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 1 Yes 2 No 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural injury 5 Pending work? 2 No Accident Investigation filled in by the Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. сопрете only one) 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** ebald 06 21 ZOU rances, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltmare Say frethell Parkeulle. MA Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number **Funeral** 12M 2□F Days 220030270 05-13-1921 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Parkville Baltimore Maryl and 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2208 Taylor Avenue 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene.
Int: If item 27 is marked other than Murray Company Machine Operator permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If item Z7 is marked other the anay Injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Mikulski Andrew Swiec 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1819 Emory Road Reisterstown Maryland 21136 Gina Sebald/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 6/23/11 Baltimore Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 01012005 Physician disease or condition resulting in death) /Medical Examiner diovascu if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy for Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ rosus 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No page 2 s autopsy performed certificate 2 10 or Attending Physician: 25. Was case referred to medical examiner? completely filled in by the funeral director, 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) A L 2 No 1 🗌 Yes 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death. To the Funeral Director: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JNP, CRNP, MIN 30. Name a address of person who completed cause of death (Item 23a) (Type, Print) Digard Br # Ca

DHMH 17 Rev 1/2001

State Registrar

Augustina 31. Date filed (Month, Day, Year)

previs-010 705

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 23, Day 2011 Year Mary Ann Spisak June 6:30 A. M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death

Baltimore County **Examiner** 4b. City, Town, or Location of Death Towson Gilchrist Hospice 5. Social Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 Year 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Director 285-14-5631 88 Yrs Sept. 08, 1922 Checkslovakia Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Monkton 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o with Funeral United States 4102 Stansbury Mill Road 21111 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Fxaminor mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1,4 or 5+) **Beautician** Beauty Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Katharine Onco John Paluga 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4102 Stansbury Mill Road Monkton, Maryland 21111 Mrs. Mary K. Radford (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of ^{20c}(Baltimore county) Timonium, Maryland Tuesday, June 28,2011 1 Burial 2 Cremation 3 Removal from State Dularey Valley Ment Cardens 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Ligen Leffrey I. Gir, S. O.S. Perfect Alternatives Funeral and Chematica Center, P.A. 2325 York Road Timonium, Maryland 21093-2215 au, B. Lic.#M00677 23a. Part 1 Energy the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cerebular disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months2 Month Year Pregnant at time of death sate has been signed by the page 2 should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by gastrointistinal blud pulmonay embalism 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ours after death.

eral Director: After this certificate I filled in by the funeral director, pagi 1 🗌 Yes 2 🗎 No 2 2-100 Yes 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? Other: Certificate: To 4 Nursing Home 5 Residence 6 Dether (Specify) Hos mr P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral L Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

State Registrar only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

JUN 2 4 2011

Partel

N Charles 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

MD

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3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

00070635

Sufe 4105 Bulhmore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per inf 991, 7-14-11 vt 17,19a State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day BENJAMIN SIPES June 2011 4:00 A^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick Social Security Number 8. Date of **Ps**th (Month, Day, March If Under 1 Year If Under 24 Hrs. 6 Sex . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Hours ^{Yea} 1930 Pennsylvania Director 177-24-6863 81 Usual Residence of Decedent show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
USA Funeral 314 W. South St Apt A 21701 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Deceuen. _____ Armed Forces? Yes 24 No 1 Never Married 2 Married Black, White, etc Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. black If Yes, Give Year or Dates Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) rould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Cooks Moving & Storage iink unk mover traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk is marked o မ Thomas Sites Sipes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sipes Sites 1 and 2 s of Health item 27 Dorothea 19312 Circle Gate Dr Apt 202; Germantown, MD 20874 daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other placel 4 ☐ Donation 5 🕅 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Konald S Was 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** momenan Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (of as a consequence of -transit requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burialcal Box 68760 Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 X No 3 Probably 4 Unknown 1 Yes Completed certificate has been s rector, page 2 should 24b. Were autopsy findings available 24a. Was an Was an autopsy performed? To the Hospital or Attending Physician: The law prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner 2 No Hospital Other: 1 Nnpatient 2 ER/Outpatient 3 DOA 1 Yes within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at work? 28d. Describe how injury occurred Matural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD 35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myung Frederick Hee MD 31. Date filed (Month, Day, Year) JUN 2 4 2011 32. Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 20^{ay} 20°1°1 7:00 Ам Janice Caroline Schmidt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 M 2 X F Months Days Hours Min. Oct 22, 1924 New York **Director** 131-14-7500 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location rector 1 Yes 2 No Towson MD Baltimore ō 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a o Funeral USA 21286 800 Southerly Rd; Apt 505 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 ☐ Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Adele May Hoffmann August Charles Koehler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 4010 Longchamp Dr #3; Austin, Texas 78746 Ronald H. Schmidt - son Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board rector 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Partyl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ooset and Death Immediate Cause (Final Ph_sician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ differy 1 ☐ Yes 2 ♥ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 Yes 2 No Manner of Death 28b. Time of 28d. Describe how injury occurred iniury 5 Pending 1 Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1) 🔁 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

JUN 2 4 2011

UMPLES

Registrar's Sign

C701 N. Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ June 1540 M Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner at And Renabilitation OFTON FINAT Munati If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** JULY 7, 1914 Months Days Hours Country 159.36.4120 96 Director Usual Residence of Decedent show 10a. State 10b. County filed within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes XX No ANNE ARUNDEL LINTHICUM 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 341 TULIP OAK CT. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married ☐ Yes 2 XX No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", Specify: Completed 3 KKWidowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working ! Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or call. ၉ pe 1 LOUIS WHITES ANNA RODIANUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON RICHARD SHUTTY 341 TULIP OAK CT. LINTHICUM, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XX Burial 2 Cremation 3 XX Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) ST. BERNARDS CEMETERY JUNE 21,2011 HASTINGS, PA Signaturito Funeral Service P.A. t/a MARYLAND MORTUARY SUPPORT 426 CRAIN HWY SW GLEN BURNIE, MD 21061 K. GREGORY FINK M01148 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Artery attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events oronaru Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) ☐ Pregnant at time of death☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Director: After this certificate 2 No Yes 2 No To Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A Physician/ Rita Elizabeth Truant sune Medical 4a. Facility Name (if not institution, give street and number . or Location of Death 4b. City, County of Death Examiner 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min Maryland 84 212-24-8412 **Director** Usual Residence of Decedent or 28a-f show notified at 10a State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕇 No Bel Air Maryland Harford 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be r Funeral USA 1303 Saratoga Drive 21014 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or il edical Examine Black, White, etc. 1 Never Married 2 Married þ 2 X No 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be filed and Mental H sis marked oth ဂ Laura (nmn) Bonolis Garibaldi (nmn) D'Amario 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1537 Charmuth Road, Lutherville, MD 21093 t of Health a Vincent J. Truant / Son Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

□ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ō Department of Important: If any injury or St. Ignatius Cath. Cem. 6-24-021 Forest Hill, Maryland McComas Funeral Home, F.A. 22. Name and Address of Facility 21, Sign Funeral Service License 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complication sanat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ End Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Director; After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 356545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygien® State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 22^{Day} 2011 June Shirley Thompson Frances 6:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Co. Timonium Stella Maris Hospice Center Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Age (In yrs. last birthday) Aug. 18, 1934 Months Days Min. MaryPand **Director** 76 219-30-3138 Usual Residence of Decedent 28a-f shov 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Dunda1k Baltimore 1 Yes 2 No ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21222 1 Roseview Road death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 YNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: 3 Divorced 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 6:30 College (1-4 or 5+) Super Fresh Grocery 8 Years Cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alta Lee Farley James A. Lumpkin 2011 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code)
1 Roseview Road Dundalk, Maryland 21222 Christopher Thompson (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Lakeview Cemetery 1 X Burial 2 Cremation 3 Removal from State Sykesview, MD 6/28/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Living 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or than failure. List only one cause on each line. shock, or be Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) COLON CANCER Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Records, P.O. Box 68760 FRANCES THOMPSON IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 X No Month signed by the at d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò Completed 2 No 3 Probably 4 Unknown page 2 should peen s 24a. Was an Were autopsy findings available has autopsy prior to completion of cause of death? To the Funeral Director: After this certificate of completed filled in by the funeral director, pag 1 Yes 2 No 1 Yes 2X No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tit 29d. Date signed (Manth, Day, Year) 201 person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, **CRNP** 2300 DULANEY VALLEY RD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ laulor Month 2:27A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore If Under 1 Year If Under 24 Hrs 8. Date of Birth 6. Sex Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) 2 27 1 🔀 M 2 🗆 F Days Hours Min. Director 9-16-570 97 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 ☐ No MD NA Baltimore ō 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 1800 Hollin Street Apt 327 West 21223 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or ð 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) grade Laborer Grace and Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown ٥ Mary L. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23868 Department of Health a Important: If item 27 is any injury or other traconce. Elva Mangrum-Niece Western Mill Road, 3197 Lawrencevill 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 L Cremauon C L 4 Donation 5 Other (Specify) Burial 2 Cremation 3 Removal from State Bethel RZUA 6/26/2011 Freeman, 21. Signature of Funeral Service 22. Name and Address of Facility
March F/H West <u>Wabash</u> more. Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line HSWD Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death page 2 should be detached signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe Yes 2 No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No funeral director. Be 26. Place of Death (Check only one) Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical 29a. Certifiei 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29b. Signaty 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) nd address of person Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 06 262011 03:25AM Theresa C. Ginska Votta Medical 4a. Facility Name (if not institution, give street and number) Jown, or Location of Death 4c. County of Death Examiner WICOMICE 1561 HOSPICE 9. Birthplace (State or Foreign If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Min. May 19, 220-22-4071 โซี 28 Maryland Director 83 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 39 Mystic Harbour Blvd 21811 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 A No Specify. Specify Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Ginski Angeline Ratajczak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>s</u> Health tem 27 1302 Cordova Greens; Largo, Florida Richard Ginski Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crest Lawn Mem.Garden 6/25/2011 Marriottsville, MD 1 M Burial 2 Cremation 3 Removal from State 5 Other (Specify) 4 Donation 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sig. ure of upral Se e License 1630 Edmondson_Avenue; Catonsville Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DISPLASE STAGE IV CHRONIC Physician/ disease or condition resulting in death) KIDNRY Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine trans, leading to immedia cause. (Disease or linjury Duri to for as a our snown on of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month Year Pregnant at time of death 5
Other (specify) Yes 9 Unknown eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Tother (Specify) HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1) Natural 5 Pending 1 🗌 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** 9:20 M 2011 Joel Christopher Vance 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Specially Hoto, tal Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1X M 2□ F 087-36-6966 69 Nov 3, Illinois Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 3838 Roland Ave; Apt 501 21211 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married white Baltimore, Marylahd 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 🕅 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any Injury or other traumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) journalist journalism 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John W. Vance Jr. Kathryn Sypher ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 Raintree P1; Winter Park, Florida 32789 Christopher Vance - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Xother (Specify) in state 4 □ Donation 21. Signature of Funeral Service Licensee Ronald S. Made Director

22. Name and Address of Facility State Anatom 655 W. Baltimore St; Baltimor 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sendomonas **Physician** resist 14 day /Medical Due to (or as a consequence of) Examiner cute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed vial burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical 0 the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? A Q cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an certificate I 2 N No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director: After ti letely filled in by the funera 28c. Injury at Work? After 1 Natural 5 Pending investigation Injury 1 Tes 2 🗌 No 2 Accident 6 Could not be determined 3 □ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide To the Hospital of within 24 hours at To the Funeral E 1 🝼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0050480 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 S. Charles St, Baltimore SEBLU ZERA-YOHANNES 31. Date filed (Month, Day, Year) State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death D Physician/ June 18^y 2011 11:55 A M Judith Annette Markley Williams Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death R Montgomery Shady Grove Hospital Gaithersburg Social Security Numbe 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month Day, 1 🗆 M 2 🔀 F Min. West Virginia 1939 Director 216-36-6705 Usual Residence of Decedent 28a-f show 10a. State 10b. County ال at 10c, City, Town or Location 10d. Inside City Limits Director SIND notified 1X Yes 2 No Rockville Maryland Montgomery 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral United States 9701 Medical Center Drive 20850 "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 271718 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Completed 3 XWidowed 4 ☐ Divorced White ed other than "natur event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Printing 12 Secretary is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ည (unk) Marklev (unk) Haddix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 33 Savage Rd Kendall Park, NJ 08824 Richard A. White / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Journey Crematory 6/27/2011 Woodbine, Maryland 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 26a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ TOP pira tal Medical resulting in death) Due to (as a consequence Examiner pilatera neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine SeIZWE disorder Cause (Disease or iinjury that initiated events resulting in death) Last for use as the burial-tran signed by the attending physician and Due to (or as a consequence of) Physician/Medical u monary Obstructive Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed? Yes 2 N 2 No 1 Yes the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at iniury 1 Matural 5 Pending 1 Yes 2 No Accident Investigation after death Director: / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) MD DOO 67386 June 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive Rockville, Maryland 20850 John, 9901 Medico MD 31. Date filed (Month, Day, Year, State JUN 2 4 2011 sacks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 8:25 P M June Joan L. Whitehouse Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 6422 Sherwood Road Baltimore Social Security Numbe 8. Date of Birth (Month, Day, Year) Aug 31, 1928 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 🔀 F Months Days Fnoland Director 213-50-2931 82 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director must be notified 1 🗌 Yes 2 🔀 No Maryland Baltimore Baltimore 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 6422 Sherwood Road 21239 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. traumatic event, the Medical Examiner Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. "natural", If Yes, Give 3 Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Tully Rachel Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i Dennis Whitehouse / Husband 6422 Sherwood Rd. Baltimore, MD 21239 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot once. 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 6/27/2011 Woodbine, Maryland 21. Sign or re of Funeral Service Ly Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician}/ MULTIPLE disease or condition resulting in death) MYELOMA Medical Due to (or as a consequence of): **Examiner** 2 years Sequentially list conditions, cause. Enter Underlying
Cause (Disease or iinjury Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☑ No
9 ☐ Unknown Pregnant at time of death
Unknown Month Dav Vear 5 Other (specify) signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 N 2 🗌 No 1 🗌 Yes Yes 25. Was case referred to medical Division of Vital the funeral director, Be 26. Place of Death (Check only one) 1 🗆 Yes 2 🐪 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 102Natural 5 Pending hours after death. Ineral Director: Af 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State

DHMH 17 Rev 7/2009

Registrar

D

BOLAIRA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7602

32. Registrar's Si

Konflower

2 4 2011

31. Date filed (Month, Day, Year,

D21022

Auto-Mo) 2123(

6-24-71

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene... For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2011 Helen C. Wise 5:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sandy Spring Friends Nursing Home Montgomery **Funeral** Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🎛 F Hours July 12, 1915 New York Director 054-03-5236 95 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard 1 Yes 2 X No Highland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7156 Mink Hollow Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White etc. þ 1 Never Married 2 Married 2 X No 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: "natural". Completed 3 X Widowed 4 Divorced White Year or Dates item 27 is marked other than "nature other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Seiler Katherina Huq Health and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille Ridlon / Niece 7156 Mink Hollow Rd. Highland, MD 20777 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 6/26/2011 Woodbine, Maryland Signature of Funeral Service L Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physiciani DEMENDA TEMS disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events attending physician and Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ the Hospital or Attending Physician: The law requires that the death Month Pregnant at time of death Dav Year been signed by the should be detached 1 ☐ Yes 2 ☑ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by INSUAN OFF CONTENT DIABITED 1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Unknown MERIN INSUAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 1 🗌 Yes the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif JUME 44, 40/1 1145947 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

4

Evelyn Jackson 5540 Ten Oaks Rd. Clarksville, MD 21029 22. Registrar's Synature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State o	of Marylar		artmen <i>tificate</i>			and M	lental Hy	giene Reg. No.	01	difference	20218)	
			Registrar Decedent's Name (First, Middle,	Last)			timodec	0.0			2. Date of Death			Т	3. Time of Death	_	
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11-04651
Robert Warzala
Physicia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	e or Maryland /		tificate of		and Mene		Eeg. No.	1 2021:		
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8760, ificate be g physici	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	e of pregna		al death	23d. Date of delive Month	ery Day Year				
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To th within To th comp	Medical	one) 2 Medical Examina 29b. Signeture and title of certifier	er: On the basis of exam and manner stated.	ination and	Vor investigation		ense number	red at the time, date				
		A. T.					C.M.E.		29d. Date signed (M. June 22, 2011	ionai, Day, Tear)		
d		30. Name and address of person who	o completed cause of de	ath (Item 2	3a)							
Ψ		Ana Rubio MD. Assist	ant Medical Exami			nore Stree	et, Baltimore,	, MD 21223				
St	ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10150 UM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richie Hospice Baltimore 5. Social Security Number 6. Sex Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country) 1 X M 2 □ F Months Days Hours 4ug^{(Month}0^{Day,} Yeg⁽71 226-39-3350 **Director** 39 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Randallstown Baltimore MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5401 Old Court Road 21133 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: white "natural", If Yes, Give 3 Widowed 4 X Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b, Kind of Business Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) self employed computers permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7520 Cranberry Ct; Hanover, Jackie Jeffries-Shaw - Friend Maryland 21076 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State cemetery, crematory or other place. Signature of Funeral Service License 22. Name and Address of Facility State Anatomy Board 36e/ Ronald S Director 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metastatiz Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year signed by the a d be detached f 2 No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 🔲 Yes Yes Hospital or Attending Physician: ision of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOUDITO: 6 Other (Specify) completed filled in by the funeral 27. Manner of Deatl 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director; 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)
JUN 2 4 2011

2. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month BESSIE TAMAYE YANO June 22, 2011 3:24P /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 804 Stone Barn Road Towson Baltimore Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day Year) 05/28/1914 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🙀 F Days Hours Min California 97 558-18-4747 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Directo 1 ☐ Yes 2 No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 804 Stone Barn Road 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXIo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 「ろeffle・Xano 6/ Baltimore, Maryland 21215-0036 1 Never Married 2 Married If Yes, Give Year or Dates þ 1 ☐ Yes 2/No Specify: 3 XVidowed 4 □ Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unk. Yemoto Unknown ၉ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Alunans 804 Stone Barn Road Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State GreenMount Crematory 06/24/2011 □ Donation 5 □ Other (Specify) Baltimore, Maryland ignature of Funeral Se 22. Name and Address of FaMirtchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, o complication shock, or heart failure. List only one complications are complicated as a complex of the compl complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or conditio resulting in death) terioscleratic Cardiavascu /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of) P.O. Box 68760 Physician/Medical use as attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Ye aı 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe this certificate 1 ☐ Yes 2 X No 2 **N**0 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

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Registrar

29b. Signature and title of certifie

31. Date filed Month

29c. License number

ill CT Lutheru

29d. Date signed (Month, Day, Year)

and manner stated.

d cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryıand		artment of t tificate of l				giene Reg. No	$2 \Pi \Gamma$		20222		
	Physicia	ın/	Decedent's Name (First, Middle HOWARD		7 N D O D					2. Date of De June 19	ath	011 Yea		3. Time of Death		
, E 14	Medic Examin	al	4a. Facility Name (if not institution		ZAPOR		4b. City, Town, o	r Location	of Death	pune 19		OLL c. County of De	eath	12:30 A™		
	Ē.		Forest Haven			Catonsv				Baltimore						
	Funeral Director		5. Social Security Number 216-28-3364 Usual Residence of Decedent	6. Sex 7. Age	e (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	8. Date of Bir Apr • I	th 1 ^y 4 ^{Year)}	9. Birthplace (State or Foreign County) Mary Land				
	show d at	tor	10a. State 10b. County		10c. City,	Town or Loc	cation					<u> </u>	100	I. Inside City Limits		
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	with the 23a or sst be	Funeral Director	10e. Street and Number 701 Edmondsor	n Ave.			10f. Zip Code 2122	8			10g. C	itizen of What	Country	1?		
36	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	by	11. Marital Status 1 □ Never Married 2 ☐ Mar	If Voc Cive ZY		1	Vas Decedent of H Yes, specify Cuba			ecify Yes or No- Rican, etc.)			ace - American Indian, ack, White, etc.			
8	hours a	Completed		Year or Dates. nt's Education		16a. Decedent's Usual Occ					16b. h	Kind of Busines	Whi ss Indu			
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ylan	ld be fi Mental arked atic ev	욘	Andrew Anthony							e (nmn)						
Maryland 21215-0036	sh is		19a. Informant's Name/Relationsl Terry Sullivar			19b. Mailin	g Address (Street Iorth Cal	and Number or Rural F		Route Number, City Suite 20		ty or Town, State, Zi		_{se,} 21202 e, MD		
ore,	f Hearlitem	1	20a. Method of Disposition 1 Burial 2 Cremation		20b. Pla	ace of Dispos	sition (Name of patory or other place			Date		ocation - City		·		
Baltimore,	t. Page tment o rtant: If rjury or		4 Donation 5 Other (S	Specify)	Hil	ltop S	Service C	orp.	6-22	2011		wson, N				
Bal	permit. Departr Importa any inji	l, d	21. Signature of Funeral Service L	licensee			Name and Addre									
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death													
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09/	cate be executed physician and s the burial-transit	edical		d												
89	certific	an/M	IF FEMALE: 23b. Was decedent pregnant									23d. Date of	f delivery			
Box	law requires that the death certificate be executed ras been signed by the attending physician and 2 Should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)					Month Day Year				
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Division of Vital Records,	To the Hospital or Attending Physician; The within 24 hours after death. To the Funneral Director: After this certificate I completed filled in by the funeral director, page		4 Homicide determ	28e. Place of Inju building, etc		ie, farm, stre	et, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	Hospi 24 hou Funer eted fill	Medical	(Check 2 ☐ Medical E	Physician: To the best of r Examiner: On the basis of ex Nurse Practioner: To the b	camination a	and/or investi	gation, in my opinio	n. death c	occurred at	the time, date a	ind place	 and due to th 	e cause	e(s) and manner stated.		
	To the within To the compl	Σ	only one) 3 ☐ Certifying 29b. Signature and title of certifier				29c. License	number			29d. Da	ate signed (Mo				
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	5		30. Name and address of person w	who completed cause of de		(Type, Pr	, Bre	fon	ore	ma	1	213	un 1			
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra					-			-1-	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DAVID ABELL JUNE 2011 1:35 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12299 DIXIE DRIVE WORCESTER BISHOPVILLE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months OCT 27, Year 1 X M 2 □ F Days **Director** 214-24-2419 MARYLAND 85 Usual Residence of Decedent 28a-f show 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MARYLAND WORCESTER BISHOPVILLE 1 Yes 2 X No 10e. Street and Numbe ò 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 12299 DIXIE DRIVE 21813 USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in LLS. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify is marked other than "natural", Completed 3 Widowed 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **ENGINEER** MANUFACTURING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည WILLIAM ROBERT ABELL MARTHA HENRIETTA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tran MARY G. ABELL 12299 DIXIE DRIVE, BISHOPVILLE, MARYLAND 21813 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CREMATORY OF DELMARVA 4 Donation 5 Other (Specify) 6/4/11 DELMAR, DELAWARE Signature of Frner / Se 22. Name and Address of Facility Þ HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician/ Medical MYRLODYSPLASTIC Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying by Physician/Medical Examiner Dun to (or as a consequence of Cause (Disease or linjury the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): by the attending physician tached for use as the burial or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2/1 No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director. After this certificate I completed filled in by the funeral director, page 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death
Natural
Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? Investigation
6
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Confidence Transport of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EHLLAN WARY ND. 733 31. Date filed (Month, Day, Year) JUN 0 6 2011 State Registrar

COSSCO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Frances Jean Baird M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Cumberland Allegany Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8 Date of Birth 1 M 2 X Days Min 08/02/1915 95 Director Maryland 214-07-2820 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 🗌 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13717 Bedford Road, NE 21502 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 should be filed within 72 hours afte and Mental Hygiene. is marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify. Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herbert John Wentz Norma Rawlings permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 906 Brentwood Street, Cumberland, MD 215 Frances R. Warner / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Sunset Memorial Park 06/08/2011 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cumberland, MD 21. Signature of Funeral Service Alsensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the bunal-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year signed by the at d be detached for 9 Unknown 9 Unknow Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) 2 No Hospital 1 Yes Other: ပ္ patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioners to the bast of my knowledge ideath consented at the firm. Jate and place, and due to the base(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mysicie -30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Grook Rd 2500 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (For State Registrar State
Registrar
Recedent's Name (First, Middle, Last)
ASCIETTO Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month 2011 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1922 Months Davs Hours Min Mar. 31 New York Director 89 068-12-9157 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2 No Prince George's Bowie MD 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 20716 USA 16101 Allenglen Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces o 1 Never Married 2X Married Yes 2 K No þ Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: White "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of ပ pe 1 Frank Alcamo Bernadette Centamore permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic & traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16101 Allenglen Ct., Bowie, MD Joseph J. Bascietto / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗌 Burial 2 🔀 Cremation 3 🗌 Removal from State Metro Crematory 6/13/2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signa r , Funeral , ervi , icensee Beall Funeral Home 22. Name and Address of Facility Bowie, MD 20715 6512 NW Crain Hwy., 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EMENT **Physician** disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or Injury that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? و ک 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has To the Hospital or with a within 24 hours after death.

To the Funeral Director: After this certificate has remained filled in by the funeral director, page? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ျှ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practions To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d Aate signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) Name and address of person who dompleted 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ :ZHAM Medical Examiner 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 2 🗆 F Months Hours Min Month, Day, Year) March 24,1942 Maryland Director 219-40-3234 69 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 🗌 Yes 2 🎇 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 810 Bulkhead Court 21409 USA or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3
Widowed 4 Divorced Specify: Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) Senior Vice President Banking Be and 2 should be filed Health and Mental Hyg 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Woodrow Wilson Beatty Mary Baier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Sharon L. Beatty / Wife 810 Bulkhead Court Annapolis, MD 21409 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 07 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ь Baltimore, MD Metro Crematory, INC. 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, any in P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ PHESTIONION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or i that initiated events the burial-trans and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atte in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autops, performed's Vas 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tes 2 No Other: ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier DU069556 jv 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 W 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 0 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 6/14/11 M.S. Kent Co. Amended #6 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) 2330 PM Month Physician/ Blackiston Hrlene red 2011 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, **Examiner** ester to wr hester enter en Kiver 8. Date of Birth (Month, Day, Ye JULY 10, 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) **Funeral** Days Hours Year) **1 X** M 2 **∑** F TENNESSEE **Director** 79 408-46-1009 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🕱 No CHESTERTOWN QUEEN ANNE'S MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Numbe Funeral 21620 UNITED STATES 300 TRUSLOW ROAD Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status an "natural", or iter Medical Examiner Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 X No þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Completed 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 73 Department of Heath and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) NEWSPAPER **TYPIST** 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY ANNIE HEATON THOMAS CLARENCE WHITLOCK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 300 TRUSLOW ROAD CHESTERTOWN, MARYLAND 21620 GEORGE BLACKISTON - HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ST. PAULS CEMETERY 06/15/2011 CHESTERTOWN, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME,
130 SPEER ROAD CHESTERTOWN, MARYLAND 21620 Signature of Funeral Service Licenses Kuks 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CORONARY STNDROME Physician ACUTE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Uniderlying Cause (Disease or iinjury ul or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death the. 1 ☐ Yes ∠ ≠ 9 ☐ Unknown g Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ CIRAMOSIS 1 🗌 Yes 2 No 3 Probably 4 Unknown ALCOHOLIC Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c, License numbe D0071130 201 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2126 21620 40005 BROWN STREET CHECKERTOWN MD KER ms 31. Date filed (Month, Da 32. Regis rar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month 5 0940 M Physician/ Nettie Pruitt Brown Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HICOMICO 9. Birthplace (State or Foreign Country) Virginia 8. Date of Birth (Month, Day, Year) 12-14-191 If Under 1 Year If Under 24 Hrs Funeral Days 1 🗆 M 2 🛛 F Months Hours Director 214-10-6105 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director 1 Yes 2 X No MD Salisbury Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1514 Riverside Drive, Apt. C105 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Mean injury or other traumatic event. The Mean Elementary/Seconday (0-12) College (1-4 or 5+) 8 Bookkeeper Bottling Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Charles Edward Pruitt Sarah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Everglade Drive, Salisbury, Maryland 21801 Richard E. Parsons - Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Church Cemetery 5-12-2011 Salisbury, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 00 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ons I d Death Immediate Cause (Final Physician/ schem 4 hours disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or). After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death Unknown Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b Were autopsy findings available 24a. Was an performed 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: ၀ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 1 Natural 5 Pending 2 🗆 No ☐ Accident Investigation the 24 hours after deat Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) the 29b. Signature and tipe of certifi 29c. License number 29d. Date signed (Month, Day, Year) 30853 376 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25 Day Physician/ Month Victor Bowen Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Penninsula Regional Medical Center Salisbury Wicomico 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Sept 24 7. Age (In yrs. last birthday) **Funeral** Year) 1950 Days Hours Min 1 X M 2 🗆 F Months 60 Yrs. **Director** 218-48-8633 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County 10c. City, Town or Location Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 USA 676 W. Main Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27; marked other than "natural", or i any injury or other traumatic event, the Medical Examin ፩ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **builder** construction Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) ပ Orlando Bowen Midge Showell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene Bowen/brother 676 W. Main Street Salisbury, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other Charles) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 🖔 Other (Specify) in state Veteran's Admin Signature of Euneral Service Licensee Ronal di art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, bock, or heart failure. List only one cause on each line. Immediate Cause (Final disease of condition resulting in death) Physician/ ASCUD Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ GI Bleed Records, Completed head a neck camer 24a. Was an autopsy Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this nartiflant 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) xaminer? 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 1 Natural
2 Accident
3 Suicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier (Check 29b. Signature and title ertifie 45049)

6-14-2011 Hurlock, MD 28 tatend Addat of Board 655 W. Baltimore Street Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 A Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 5/26/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHYDE 100 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009 ORIGINAL

3. Time of Death

1639

Birthplace (State or Foreign Country)
 unk

black

10d. Inside City Limits

1 Tes 2 No

Registrar

BIOI Salisbury

560 Riverside

32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

Reilly

JUN 09

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06 ^{Year} 2011 Physician/ 4:43 Nancy L. Brown, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury None Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 10/05/1923 Days Hours 1 🗆 M 2 🕱 F VA Director 87 082-20-1015 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director or 28a-f she notified 1 X Yes 2 No Salisbury MD Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be "natural", or items 23a edical Examiner must be Funeral **USA** 21801 4852 Goose Creek Dr.. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Yes, Give 2 🗶 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify 3 ₩ Widowed 4 □ Divorced Black Year or Dates ed other than "natur event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Caregiver 11 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ruth Fisher William Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4852 Goose Creek Dr., , Salisbury, MD 21801 Peggy Stewart / Daughter Department of Health Important: If item 27 any injury or other trong once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State 6/12/2011 Bloxom, VA Macedonia Baptist Cemetery Donation 5 Dther (Specify) 22. Name and Address of Facility Cooper & Humbles Funeral Co., Inc., Accomac, VA 23301 replications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Part 1. Enter the disease, or co Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Year for Month Dav Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by a □ No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 7 No certificate 1 Yes ours after death.

eral Director: After this certific filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 No 1 🗌 Yes |@ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral Completed filled is Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 202 Po WA 31. Date filed (Month, Day, Year) 08 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Ethel Barnes Berry 2011 0400 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomic Salisbur abilitation & Nursing Ctr If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Hours 054-14-8069 97 0672271913 Maryland Director Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f 1 X Yes 2 ☐ No Maryland Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 709 Schumaker Lane 21804 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: "natural" Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Joshua Barnes Rachel Leight 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10101 Reed Lane, Ellicott City, MD 21042 Franklin Berry/son Department of Health or other Baltimore, Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Wicomico Memorial Park 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 M Other (SErvicombment 6/13/2011 Salisbury, MD 21. Signature of Funeral Service Licenses 22 No. 12 Address of Figure 2 Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ ac disease or condition resulting in death) 6 Medical Due to (as a cons uenc Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner (or as a consequence of Cause (Disease or iinjury the attending physician and hed for use as the burial-trans that initiated events resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsv death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death Check only one) the funeral director, Be examiner? 2 400 Other: 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Avatural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Grifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of c Name and address of person who completed cause of death (Item 23a) (Type, Print) liam

DHMH 17 Rev 7/2009

Registrar

Date filed (Month, Day, Year)

JUN 08

Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item# 30 Per DVR, g916 6-24-11 sm State of Maryland / Department of Health and Mental Hygiene | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:40AM Mildred T. Becker 2011 une Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hartoro Havre de Grace NIDING Home Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 WF Days Hours Min. Country 219-28-3026 79 Director aruland 09/02/1931 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 X Yes 2 No MD Havre de Grace Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral U.S.A. Washington Street within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc. þ 1 -Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White Completed 3XXWidowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 1 any injury or other traumatic event, the Meginee. Elementary/Seconday (0-12) College (1-4 or 5+) Civil Service Gavernment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charlotte E. Marlowe John P. Hines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 S. Washington Street, Havre de Grace, MD 21078 Gloria Day (Sister) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 \square Burial 2 \boxtimes Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/17/2011 West Chester, PA R.A. Ferris 22. Name and Address of Facility Zellman Funeral Home, P.A. ature of Funeral Service Licen Washington Street, Havre de Grace, 23ar Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ta Pa VI disease or condition Medical Examiner resulting in death) Due to or as a consequence of Sequentially list conditions, Examine if any, leading to immediate cause. Enter, Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mor Month Day Year 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe After this certificate 2 🗆 No Yes Vita completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 1 Tyes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 🗌 Natural 5 Pending work 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29d. Date signed (Month, Day, Year) 29b. Signato 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2027 Pulaski Highway Suite: 203 Havre De Grace, MD, 21078 Robert Rapp Jr. 31. Date filed (Month, Day, Year) State Registrar

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Antonio Castrilli 1607 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-Regional Medical (enter Allegany Cumberland If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral New Jersey 1 X M 2 □ 07/09/1931 79 **Director** 150-24-2034 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits Examiner must be notified at 10c. City, Town or Location Director Bedford Bedford PA 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö 15522 Funeral 7131 Bedford Valley Road items 23a 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1951–
If Yes, Give
Year or Dates. 1953 Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 - Widowed 4 X Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Gas Utility Meter Reader Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) permit. Page 1 and 2 should be filt Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve once. 2 Gaetano Castrilli Carmella Formicelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5133 Killarney Hope Drive, Raleigh, NC 27613 David Castrilli / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 06/06/2011 Basking Ridge, NJ 21. Sign turn of Tuneral Service of 22. Name and Address of Facility Adams Family Funeral Home, F.A. 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ congestive heart tailore Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 1 | Yes 2 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ embolism 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has the funeral director, page 2 performed Yes 2 this certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Sign atur 29c. License number 2 29d. Date signed (Month, Day, Year) 8216 6+ ause of death (Item 23a) (Type, Print) 12501 Willowbrook Rd Comberland MO 21502 31. Date filed (Month, Day, Year) State JUN 0 2 sach Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 27, 2011 Year 11:15 M Steven Troy Cadwallader Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 19825 O'Mara Avenue Midland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) June 15, 1964 Country) Maryland 1 M 2 🗆 F Months 218-90-8454 Yrs. Director 46 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f 1 XYes 2 ☐ No Midland Maryland Allegany 10e. Street and Number ms 23a or r must be r ō 10f. Zip Code 10g. Citizen of What Country? Funeral 19825 O'Mara Avenue 21542 USA permit, Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Towing 12 Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Cadwallader Ruth Stevenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jenny Lyn Cadwallader - Wife 19825 O'Mara Avenue, Midland, Maryland, 21542 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory 20a. Method of Disposition 20c. Location - City or Town, State DateMay 28, 1 Burial 2 Cremation 3 Removal from State Cumberland, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. orval Between iset and Death Interval Between Immediate Cause (Final Physician/ disease or condition / Medical resulting in death) **Examiner** Sequentially list conditions, Examiner Due to (or se a consequence or): if drily, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 Yes 2 No page 2 should be detached for Month Day Year Pregnant at time of death Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 **P** No 3 □ Probably 4 □ Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I Yes completed filled in by the funeral director, 25. Was case referred to dica Be 26. Place of Death (Check only one) examiner? 2 No 10 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Tyes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ced 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Month 6 Day G cla 1423 ramo Medical Facility Name (if not institution, give street and nur. Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical Center Baltimore Baltimore City If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Washington, D.C 217-72-7694 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Talbot Easton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29720 Lakeview Ct. 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 No Specify "natural", Completed 3 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaker Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked o ၉ William Harold Blackwell Patricia Ann Dodson 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traconce. Clark James Crampton, Sr. 29720 Lakeview Ct. MD 21601 Easton, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔣 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/14/2011 Waldorf, Maryland Trinity Memorial 21. Signature of Funeral Service License 22. Name and Address of FacilityBrinsfield-Echols Funeral Home PA Three Notch Rd., Charlotte Hall, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line hemorrhagic Immediate Cause (Final neet an Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence) Examiner ngestive Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death the g Unknown Linknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy 2 No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 Tyes 욘 1 X Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28b. Time of Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No s after death M Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie RN 960460 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21201 Dees aa√n ก (greene 31. Date filed (Mor State 5 Registrar

Amend #22 per FD Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AACO Health Dept 6-8-11 KAH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 30 Day Physician/ 2011 May 5:28P M Elizabeth Coates . Medical 4c. County of Death a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 940 Bay Forest Ct. Apt Annapolis 9. Birthplace (State or Foreign Date of Dis... (Month, Day, Y 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Days Country) Maryland Hours 1 □ M 2 🔽 F 90 Yrs. Dec 920 Director 219-16-2328 Usual Residence of Decedent show. 10d. Inside City Limits items 23a or 28a-f shor ner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Anne Arundel Annapolis Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21403 940 Bay Forest Ct. Apt 301 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2 any injury or other traumatic event, the Medical Examination. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: If Yes, Give **Black** Completed 3X Widowed 4 □ Divorced Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Hote1 11th U Waitress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary Hebron Norman Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Central St. Annapolis, Md. 21401 Norman Johnson (Nephew) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 6-3-11 Crownsville, Maryland Veteran : 4 ☐ Donation 5 ☐ Other (Specify) Miname a Receise of Facility Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 1922 Forest Dr. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 use as 1 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No been signed by the atte should be detached for Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🚉 Unknown Division of Vital Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To this funeral 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No s after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after dea

To the Funeral Director

completed filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Scrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur D0062349 JUNE 06 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2002 MEDIUL PARICUAT #670 ANNAPOUS MD 21401 MCGLONS MO

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ 20 0400 M Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year 919 Massachusetts 1 **№**M 2 □ F Days Hours June 26 Director 020-03-1629 Usual Residence of Decedent of Heath and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1

✓ Yes 2 □ No Prince George's Bowie MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20716 3850 Enfield Chase Ct., #304 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give ģ. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify:White Completed 3X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Government 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Printing Office Electrician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice McCarthy Joshua W. Church permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bowie, MD 20716 1217 Port Echo Lane, Alice Church / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 6/10/2011 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility Beall Funeral Home 21. Signature Bowie, MD 6512 NW Crain Hwy., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph__ician/ disease or condition resulting in death) Examiner Sequentially list conditions, tary, leading to in modiate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 No , page 2 s this certificate has death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No dea h. Investigation Accident 24 hours fter dean Funeral Lirector: the 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗖 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and tile of certif 6-04-2011 0060225 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Pkwy, Annapolis, MD STEVEN

8

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 0 8 2011

32. Registrar's Signature

11-03968	
Anthony Carlson	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nthony Carlson	State of Maryland / Departm:	ent of Health and Mental Hy ate of Death		Some on him had not						
/Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		Reg. No. 2. Date of Death	3. Time of Death						
ledical Examine	Anthony Carlson	Month Day Year May 27, 2011	1745 hrs							
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death							
<i></i>	Rocks State Park	Jarrettsvile	Harford							
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	Foreia	hplace (State or n						
Director	543-37-2109 1⊠M 2□F 19	Yrs.	08/06/1991 co	untry)Oregon						
à.	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town	or Location		10d. Inside City Limits						
_ A0 43	MD Harford Edgev			1 Yes 2 No						
Aaryland 28a-f show any 1 at once. ector	10e. Street and Number	10f. Zip Code	10g. Citizen of What Coun	ntry?						
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ral", or	3 Widowed 4 Divorced If Yes, Give Year 2010-11	1 Yes 2 X No specify:	Specify: Whi	ite .						
ours a	45 Decedents Education (Pageils, only highest grade completed) 169	Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retir		ndustry						
0036 within 72 hour giene. her than "natu her than "matu Medical Exar ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)									
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115-	Robert Edwin Carlson		Theresa Meedom							
ould be d Menta s mark		b. Mailing Address (Street and Number or R		, Zip Code)						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Judy Theresa Meedon / Mother	7835 South West Olesc								
G, C, L and I and Healt Healt Fittem		of Disposition (Name of cemetery, ory or other place)	Date 20c. Location - City or	Town, State						
Pages ent of nut: I	I I Spurial 2 Clemation 3 24 Removal nom State	mette Nat'l Cem. 06/	11/2011 Portland,	OR						
Baltimore, pernit. Pages la Department of He Important: If ite Impyrant or other tr	21. Signatur of Fineral Service Licensee		eall Funeral Home							
w 5913	11 pm	6512 NW Crain Hwy.								
Physician Wedical	23a Part I. Enter the disease, or complications that caused the death. Do no failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac or	respiratory arrest, shock, or heart	Approximate Interval Between Onset and						
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ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):			100						
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ox 6876(eath certificate the attending physic ruse as the bisical physical	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Pregnant at time of death	Fetal death 3 Ectopic pregna	ncy Month D	Day Year						
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P.O. Be that the de ned by the detached f	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?						
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Division of Vital Records, talor Attending Physician: The law requirers after death. al Director: After this certificate has been siled in by the funeral director, page 2 should berification: To Be Completed	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	utpatient 3 DOA Other Nursin		: Scene						
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sior ttend death. ctor: y the	2 ✓ Accident Investigation May 27, 2011 173	0 hrs	OOS I and the Object and Number of Di	and Doute Number City						
Jor A after after I Dire	The part of the pa									
ospits hours unera										
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the tellical Certification: To Be Completed by Physician/Meledical Certification: To Be Completed by Physician/Meledical Certification:										
To with the con	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Mod	nth, Day, Year)						
	my his. Va	O.C.M.E.	May 28, 2011							
AK MILL	30. Name and address of person who completed cause of death (Item 23a)									
3	Ling Li, MD Assistant Medical Examiner 900 W. E	Baltimore Street, Baltimore, MD 21	223							
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	back								

State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month June 2011 Physician/ 8:30 PM James Lee Carpenter Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Regional Hospital Laurel aure 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8 Date of Birth Social Security Number Funeral March 47, Ye 1938 Washington, DC 1 🗓 M 2 □ F Months Days Hours 73 578-50-1621 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🗓 No Maryland 1 4 1 Prince Georges Laurel 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral TISA 14200 Laurel Park Dr. 20707 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 If Yes, Give 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3 Widowed 4 X Divorced Completed Year or Dates. 55-16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) onday (0-12) College (1-4 or 5+) Automotive Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) ျ Lulu Ouackenbush Edward L. Carpenter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24042 Jacana Circle, Laguna Niguel California 92677 Janet L. Thomas-daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Laurel, Maryland Baltimore Washington Crem June 7, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Pervice Licensee 22 Name and Address of Facility Fleck Funeral Home, Inc. MO1234 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner 3-4 days Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) Pregnant at time of death 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 40 မ 1 Hipatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No completed filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred Certificate: injury 1 Hatural 5 Pending Investigation Accident within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Hospital Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ပ 04 DETSADIF Van Dusen Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2070 aurel Regional Hospital MI Laurel DETSA 31. Date filed (Month, Day, Year)

JUN 0 8 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Month Physician/ 3:10 AM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Care Dorchester 'enter 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral 1 D M 2 D F Months Hours **Director** Maryland JU14 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location event, the Me Acal Examiner must be notified at Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Numbe Funeral "natural", or items 23a 215 Baltimore, Maryland 21215-0036 V Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72! the and Mental Hygiene.

7 is marked other than "r. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Maryland 2/6/3 Blanche 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place; Pleasant Cemet 4 Donation 5 Other (Specify) 6 Signature of Funeral Service Licenses uneral snington st Pat-1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ IRREVERSIBLE CACHEXIA NATURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions it cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of burial-transi Due to (or as a consequence of) Ш resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 the as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death use a 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy
 Other (specify) for L in the past 12 months? Month Dav 1 Yes 2 L 9 Unknown sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 🗌 Yes 2 🗗 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗗 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 99 D 69 234 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JEEVAN ERRABOLU 503 BYRN STREET CAMBRIDGE MARYLAND 21613 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ 40 PM 2011 Lorraine F. Collier Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (if not institution, give street and number) **Examiner** ho mico Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Hours 12 31 1920 West Virginia 234-44-9836 **Director** Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21804 1207 Belmont Ave. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married Completed by しのアグル しかけばん Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Brownie DeHart George Dewey Johns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1207 Belmont Ave., Salisbury, MD 21804 Charles Collier husband 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Springhill Memory ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05|10|2011 Hebron, Maryland Gardens Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 21, Sign Jure of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death THROMBOCY TOPBNIC Ph i ian/ IDIO PATHIC disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** PRIZTRS10~ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Year Pregnant at time of death been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 🗌 Yes 2 🖼 25. Was case referred to medica Be 26. Place of Death (Check only one) 2/17 No Other: 4 Nursing Home 5 Residence of Other (Specify) HOSPICE 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 🗂 Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No after death. Accident Suicide Investigation Could not be completed filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 L Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2120 6 Hauson 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dorothy Mary Chestnut Cheetham 8: 45 AM 05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BOASTAL HOSPICE JALIS BU WICOMICO THE LAKE AT 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/20/1925 **Funeral** 1 🗆 M 2 🏻 F 056-20-4596 85 Director Massachusetts Usual Residence of Decedent ms 23a or 28a-f show must be notified at with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 318 Troopers Way 21801 Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner munor or other traumatic event, the Medical Examiner munor or other traumatic event. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married If Yes, Give Year or Dates Yes 2 X No Specify: white Completed 3 X Widowed 4 Divorced Specify: 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Government Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johanna O'Meara Henry George Chestnut 19a. Informant's Name/Relationship (Type, Print)
Barbara Kreiser/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 315, Hebron, MD 21830 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Eastern Shore of MD Important: I any injury o 4 Donation 5 Other (Specify) 5/20/2011 Hurlock, MD Veterans Cemetery 21. Signature of Funeral Service Licensee ²²Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause (Disease or iinjury Quality for as a consequence of been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Day Year Yes Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Euneral Director: After this certificate has I to the Euneral Director. After this certificate has I to the Funeral director, page 2 ? autopsy performed' death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 🔀 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury_at 28d. Describe how injury accurred 1 🗷 Natural 5 Pending work? 1 ☐ Yes 2 🗌 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ☐ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifig (Sept 29505 05-15-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BEL L090 5302 CHINABERRY DR. SALISBURY MD 21801 31. Date filed (Mor Registrar's Signat State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ollie 2:05P 31 2011 May Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Fort Washington 8. Date of Birth (Month, Day, Year) Fort Washington Medical Center Georges Prince Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Days Min 451-48-7148 75 Yrs. Director Texas Usual Residence of Decedent show 10a. State notified at Director 10c. City, Town or Location 10d. Inside City Limits 28a-f MD PG 1 XYes 2 No Fort Washington 10e. Street and Number 10f. Zip Code 109, Citizen of What Country? ms 23a or must be n Funeral 3604 Stonesboro Road United States ral", or items? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 N Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Chief Warrant Officer II US Army 5+of Health and Mental Hygi item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Rosella Ollie Evans Coe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3604 Stonesboro Road Fort Washington, MD. 20744 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Edgie E. Coe/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 9/22 11 1 XBurial 2 Cremation 3 Removal from State Arlington Nat. Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. Silver Hill Rd., Suitland, MD. 23a. Part 1. 5 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot of respiratory arrest, shoot of the respiratory arrest, shoot of the respiratory arrest. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Cardiovesseylando Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a o attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \) 2 \(\subsete \text{ No} \) Day Year Pregnant at time of death the □ Unknown 9 Unknown P.0. cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😓 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe this certificate 2 No Yes 2 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 Total Outpatient 3 Inpatient 2 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of e Hospital or Attending Pl 24 hours after death. e Funeral Director: After th 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) injury 5 Pending work? 1 ☐ Yes 2 ☐ No. Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer 1004 30. Name and address of person who ted cause of death (Item 23a) (Type, Print) 40001 1171 31. Date filed (Month, Day, State Registra

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Maryland 21215-0036

Baltimore,

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permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve

Physician/

Examiner

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ William Thomas Damm, Jr. 8:15 May 2011 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. 1 😾 M 2 🗆 F 0872 Py 1928 82 Marviand 213-34-6811 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Cumberland MD Allegany 1 X Yes 2 No 10g. Citizen of What Country? USA 10e, Street and Number 10f. Zip Code Funeral 505 Magruder Street 21502 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify: White Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Navy Aviation Machinist Mate Chief Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Brant Ethel William Thomas Damm, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Magruder Street, Cumberland, MD 21502 Edith E. Damm / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State MD Vet Cem @ Rocky Gap 06/01/2011 Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. of Funeral Service 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 20 days Immediate Cause (Final disease or condition resulting in death) Subdural Hematoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 X Yes 2 □ No Hospital: Other: ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 🗓 No Accident 8:30 A M Patient Fell 05/07/2011 Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
At home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 505 Magruder Street Cumberland, MD 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Welfall Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 28, 2011 D09157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Paul Snow, M.D., 124 West Third Street, Cumberland, MD Paul Snow, M.D.,

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month,

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32. Redistrar's Signature

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		-	For State Registrar	na Mentai Hy	Reg. NO 0 1 1 0 0 0 1 6									
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7,44			5. Social Security Number 6. 5	809 Broad Stre	et e (In yrs. las	t hirthday)	If Under 1 Year	If Under 24	Midland Hrs. 8. Date of Bir	<u> </u>		Allegany 9. Birthplace (State or Foreign		
	Funeral Director		220-16-5477	1 M 2 DF	87	Yrs.	Months Days		Min. (Month, Da Mar	ch 27, 19	924 9. Birth	haryland		
	and show Lat	o	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation				11	10d. Inside City Limits		
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(0	or items	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent E Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Yes} \)		13. V	Vas Decedent of Yes, specify Cub	Hispanic Origin pan, Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)		14. Race - Americ Black, White, e			
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, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Daniel De	Type, Print) evlin - Son	- 3	19b, Mailin					City or Town, State, Zip Code) t City, Maryland, 21042			
Baltimore,	Page 1 an nent of He int; If iten iry or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		20b. Pla cer	metery, crem	sition (Name of latory or other pla erland Crema	ace) tory	Date May 27, 2011	20c. Lo	cation - City or To Cumberlan	own, State nd, Maryland		
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'ds'	v requires been sign should be	ted b			-				1 🗆	Yes 2 [I NO 3 □ Prob	bably 4 🗆 Unknown		
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3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory of														
_	To the Hospital or A within 24 hours after To the Funeral Dire completed filled in b	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.												
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Inn. frant: If item 37 is marked other than "natural", or items 23a or 28a-f abo injery or other traumatic event, the Medical Examiner, must be notified at once.	ı	20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Sp	ecify:	Removal from State	Bet	ace of Dispo ematory or o hel U. emeter	ther place			6/14	Date 4/2011		Location -	•	.tch, MD	
Balti permit. Departur Im ru		27 Signature of Funeral Service Licensee 12 Signature of Funeral Service Licensee 12 Signature of Funeral Service Licensee 13 Varie and Address of Facility I Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interview.												on		
Physician /Medical Examiner	855	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	complited on each li a. Hy	tions that caused the ine. pertensive Athe	eroscle	rotic Card				cardiac or	respiratory a	ırrest, sh	nock, or hea	rt	Approximate Ini Between Onse Death	
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lox 68760, leath certificate be attending physici for use as the buri	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unk	4	Live birth Pregnant at tin	ne of dea	_ = =	etal death ther (Sp		Ectop	ic pregna	ncy		Month	D	ay Yean	
P.O. Es that the canada by the detached	<u>조</u>	Part II. Other significant conditi	ions cor	ntributing to death b	ut not res	sulting in the	underlyin	ng cause	given in P	Part I.					he cause of death	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Completed										per	opsy form <u>ed</u> ?	p d	nor to co	opsy findings ava	e of
Re: The iffcate	ខ្ញ	25. Was case referred to medical						26 Place	e of Death	(Check o		2	No 1	√ Ye	s 2 N	lo
lirecto	۵ï	examiner?	Hosp	pital: 1 Inpatient	2 E	R/Outpatien	t 3	DOA	-		g Home 5	Resid	dence 6	Other	Scene	
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Division tal or Attendi rs after death.	Certification:	3 Suicide 6 Coul	stigation d not be rmined	28e. Place of Injur	y - At hor	- At home, farm, street, factory, office building, etc. 28f. Locati					28f. Location or Town	n (Street and Number or Rural Route Number, City n, State)				
Divisior To the Hospital or Attend within 24 hours after death within Funcral Director: completely filled in by the	Medical Co	29a. Certifier 1 Certifying Pt	miner:On	To the best of my k												
To To	₩.	29b. Signature and title of certifie		d manner stated.	_		29	9c. Licen	se numbe	r		29d	l. Date signe	d (Mor	th, Day, Year)	4
16		fur C		MA	th //th :: :	220)		O.C.	.M.E.			Ju	ne 9, 201	11		_
()	- 1	30. Name and address of person	WITO CODS	pieteo cause of dea	auti (Item 2	234)										

Russell Alexander MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 2011 State Registrar

900 W. Baltimore Street, Baltimore, MD 21223

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Melvin Rov Driscoll Month June 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2011Sbur Wicomico Peninsula Regional Medical conter Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 218-50-0929 06/26/1947 Maryland 63 **Director** Usual Residence of Decedent 10a. State 10b County with the Maryland 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f Maryland Wicomico Parsonsburg 1 🗌 Yes 2 🔀 No 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5633 Forest Grove Road 21849 USA Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ρ 1 Never Married 2 K Married "natural", or Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 Divorced Completed Specify: White the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Melvin Earl Driscoll Adelean Grace Messick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5633 Forest Grove Rd., Parsonsburg, MD 21849 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Rosalie Driscoll/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Springhili Memory Gardens 4 ☐ Donation 5 ☐ Other (Specify) 6/13/2011 Hebron, MD 21. Signatury of Funeral Service Licenses HolToway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 No Hospital or Attending Physician: 1 24 hours after death. Funeral Director: After this certifics 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🖟 No Other: ဂ 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 \square Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certific Date/signy 370 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 31. Date filed (Month, Day, Yea State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wilmer Davis 2011 0900 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10125 Teagle Road Berlin Worcester 8. Date of Birth (Month, Day, Year) Jan 7, 1935 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 🔀 M 2 🗆 F 76 **Director** 220-28-4748 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits irector 10c. City, Town or Location MDWorcester Berlin 1 XYes 2 No Ö 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a o Funeral 10125 Teagle Road 21811 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 African If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced American er than "natur , the Medical B 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) r and Mental Hygien 7 is marked other the Laborer City Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it. Page 1 and 2 should be fill thent of Health and Mental rtant: If item 27 is marked viury or other traumatic ev 2 Ward Ben Davis Annie Belle Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley M. Davis/wife 10125 Teagle Road, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or oth Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) New Bethel UMC Cem 6/9/2011 Berlin, MD 22. Name and Address of Facility
Lewis N. Watson Funeral Home,
1618 West Rd., Salisbury, MD 21. Signature of Euneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician COLON ARCINDONA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2/2 No Records, 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe funeral director, page 2 certificate 2 48 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) Residence 6 \(\text{Other} \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DCA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 2 Accider After injury 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0058410 SACYBUY WD 21802 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WARKS 1500 Registrar's Sign Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death /2 Month Physician/ 2011 07:27 M Dorothy Holt Dolby JUNE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death <u>Peninsula</u> Regional Medical center Nicomico alisburu If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Date of Birth **Funeral** 1 □ M 2 🖾 F Months (Month, Day, Year, 21, 1 Hours 222-16-9469 Director 82 Sept. Usual Residence of Decedent 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DE Laurel 1 Yes 2 X No Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 109 Broadcreek Road 19956 Lakeside Manor Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. white Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Fred Holt Geraldine Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19956Lakeside Manor Laurel, DE 109 Broadcreek Road Harvey Dolby (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State Crematory of Delmarva 06-06-2011 4 Donation 5 Other (Specify) Delmar, Delaware 21. Signature di Funeral Service Licensee 2. Name and Address of Facility Phort Funeral Home 3 East Grove Street -0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ SILERY CODONARY WARRY BYCKS Medical **Examiner** INFARCTION (Or MYOCARDA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been simpal by the Attending Laborator. Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month 5 Other (specify) Pregnant at time of death signed by the a d be detached f g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been siç r, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? apleted filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 No Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only ong 29b. Signa ure and title o 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

68760

Box

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month D(P Year Susan Carrington DeVincentz 253 PM Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TENINSUID SACISHIM Niamico Social Security Numbe 9. Birthplace (State or Foreign MD If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 1 □ M 2 🛛 F Days 8-26-1970 Hours Director 219-06-7454 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Somerset Westover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29769 Kingston Lane 21871 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Page 1 and 2 should be filed within 72 hours aft ment of Health and Mental Hygiene, ant: If item 27 is marked other than "natural", If Yes, Give Year or Dates SpeWhite Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaking Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Earl R. DeVincentz Katie Y. Bradshaw 19a. Informant's Name/Relationship (Type, Print) Parents 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 2 & Katie DeVincentz 29769 Kingston Lane, Westover, <u>MD 21871</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2X Cremation 3 🗀 Removal from State injury or 4 Donation 5 Other (Specify) **Direct** Cremation, 6-6-2011 Dover, DE Bennie Smith 917 W. Isabella St. 21. Signature of theral Service Lious Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Multiorgan dustunction syndrome Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year ☐ Yes ← ☐ Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cirrhosis 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: မြ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 5 Pending work' 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29h. Signature and title of certifier 29d. Date signed (Month. Day, Year) D0070461 2011 person who completed cause of death (Item 23a) (Type, Print) R.M.C. 100 E Carroll State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lilly Ann Dorsett 5.07 PM 2011 TUNE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Prince Georges **Examiner** 4b. City, Town, or Location of Death Doctors Community Hospital Lanham 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 X F Days Min 11/18/1928 224-34-7707 82 Virginia **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince Georges Lanham 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9301 Calanda St. 20706 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 XNo 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Chattie M. Jones Richard Finney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9301 Calanda St. Lanham, MD 20706 Garland Dorsett (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Highland Burial Park | 06/12/2011 Danville, Virginia 21. Signature Rendon/Hale Funeral Home 22. Name and Address of Facility 9013 Annapolis Rd. Lanham, MD 20706 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anock, or heart failure. List enly one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner DSTRIDIUM Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Month Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIBRILLATION 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 2 No Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA this (28a. Date of injury (Month, Day, Year) 27. Manuer of Death Certificate: 28b. Time of 28c. Injury at work? 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1: Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 within 2 To the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00050951 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Riverdologia sello 2400 AUR Konelworth 6510, 31. Date filed (Month Day, Year) 32. Registrar's Signature State JUN 1 3 2011 Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5-27-201 Day Physician/ Isabelle W. Davis 3:37 p Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico 304 Ferry Street Sharptown If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Months Hours 1-29-1924 Delaware 221-14-5662 87 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No Sharptown Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 304 Ferry Street 21861 Wicomico 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No Specify: Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Sales Grocery Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Elwood Wheatley Alda Brittingham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) John Davis (Husband) 304 Ferry Street Sharptown, Md. 21861 20b. Place of Disposition (Name of cemetery, crematory or other place)

Laurel Hill Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State June 2,2011 Laurel, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 700 West Street 21. Signature of Funeral Service Licenses Hannigan, Short, Disharoon F.H. Laurel, De. 19956 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician em disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) be detached i g Unknown the 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Tes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No 1 Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other} \) Other (Specify) Hospital: 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending 1 Natural 1 🗌 Yes Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058400 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.0 1300 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Eugene Raymond Funk, Jr. 2ິດ11 June 12:20 Α Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Allegany 11206 DeHaven Road Cumberland 8. Date of Birth (Month, Day, Year) 06/01/1941 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs . Age (In vrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F Months Hours 220-38-0028 Director 70 Maryland Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at with the Maryland Director 1 🗌 Yes 2 🛣 No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21502 11206 DeHaven Road death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin once. δ 1 Never Married 2 X Married 1 X Yes 2 No 1959-If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed 1963 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plate Glass Laborer Be 18, Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Logsdon Funk, Sr. Katherine Matilda ပ Eugene Raymond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 11206 DeHaven Road, Cumberland, MD 21502 19a. Informant's Name/Relationship (Type, Print) Catherine L. Funk / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Mem. Park 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 06/04/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Rome, P.A. Scriature Funeral Service Lice 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final P ician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for a Month Year Other (specify) 4 Pregnant Pregnant at time of death Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or constitution within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page? performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 Yes 2 No 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred iniurv 1 Natural $5 \square$ Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗍 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year) June 2, 2011 D0022029 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Riaz A. Janjua, M.D., 625 Kent Avenue, Cumberland, MD

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Pax, Year) 3 2011

sarked

egistrar's Signature

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 11, 2011 Charles Hallie 11:38 A Finn Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince George's Clinton Social Security Number If Under 1 Year 8. Date of Birth 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Months Min. 78 Washington DC **Director** 1932 577 42 6772 July 10. Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD 1 Tes 2XX No Prince George's Accokeek 10e, Street and Numbe 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. But a fire a fire a fire a fire a fire and a fire and a fire a f 18501 Indian Head Hwy United States 20607 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. med Forces? Black, White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 XXYes If Yes, Give 1 ☐ Yes 2 🙀 No Specify: Specify 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ross Hofman Finn, Sr. Evenlyn Rose Alvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Jean Finn (Wife) 18501 Indian Head Hwy, Accokeek, MD 20607 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify Maryland Veterans Cemetery June 21, 2011 Cheltenham, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral Service License Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Phy i ian disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown detached Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: မ 1 XInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 K Natural injury 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) the Hospital within 24 hours and To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Continuing Nurse Practioner: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20 // FLANNER 1400 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F 89 Months Days Hours Min Janonth, 29, Year 922 NY 089-12-1230 **Director** Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 20906 USA 14809 Pennfield Cirlce, Apt. 102 should be filed within 72 hours after death and Mental Hygiene.
is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. P. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Valentine Burke Katharine English 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other tra Kevin B. Flannery/Son 3601 King William Drive, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Gate of Heaven Cemetery 1 Burial 2 Cremation 3 Removal from State June 14, 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 00 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 20 years Immediate Cause (Final Physician/ PULMONARY FIBROSES disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir and I-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COLON CANCER Records, Completed 1 Yes 2 No 3 Probably 4 Unknown COROMARY ARTERY PESENSE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No of Vital Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA nin 24 hours after death.

the Funeral Director; After thi

npleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 X Natural 5 Pending injury Division 2 Accident
3 Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the Comple 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Um . Luc 023630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 16220 GREDERZER RODO #213 GAZTHERSBURG, MARTLAND 2087) FRANK J. MAND, AP 31. Date filed (Month, Day Year) 3 2011 32. Fegistrar's Signature State barks Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 0707 Robert Forester Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton Hospital Union 8. Date of Birth (Month, Day, Ye March 25. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral 1 🔀 M 2 🗆 F Months Hours Min. 1955 Director 56 185-38-41 edent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No **Œ**cil Elkton MD10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21921 USA 115 Brantwood Drive items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. "natural", or p 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineer *Aerospace* 1 and 2 should be filed with f Health and Mental Hygien item 27 is marked other th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosemery Adams Robert Charles Forester, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t of Health Linda Forester/Wife 115 Brantwood Drive, Elkton, MD 21921 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) permit. Page 1
Department of
Important: If it 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rose of Lima 6/13/2011 Chesamake City, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Daniels & Hutchison Funeral Home, LLC, value on each line. Approximate 23a. Part 1. Enter the disease, or com-Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final Aspiration Physician/ neumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit Exami Ren Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🛣 No Year signed by the atte Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Diabetes Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed, Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 💢 No ဂ္ 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and phase, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0068591 June 07,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lera-Ayotte Liana 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Κ. Fitzgerald James Jr. JUNP 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NICOMIC RICIONAL SALISBURG 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 - F Months Hours (Month, Day, Year) 09/29/1929 81 **Director** 215-26-4598 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is anaked other than "natural", or items 23a or 28a-1 sho important: If item 27 is anaked other than "natural", or items 23a or 28a-1 sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30330 Zion Road 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by If Yes, Give Year or Dates. 1 Tes 2 No Specify: Specify: White 3 Divorced 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner Sporting Goods 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be file ment of Heaith and Mental I: tant: If item 27 is marked o James K. Fitzgerald Sr. Nancy Catherine Downes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30330 Zion Rd., Salisbury, MD 21804 Margaret Fitzgerald/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date Wicomico Memorial Park 1 X Burial 2 Cremation 3 Removal from State 6/7/2011 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licenses HOTTOWAY Funeral Home Professional Ass 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ etastal disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown has been signed to the second Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? After this certificate I funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate; 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fun 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JALISBURY MD

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

11-04487 Suzanne E. Garner

Medical Examiner

Funeral Director

Physician/

20a. Method of Disposition

Donation 5

Immediate Cause (Final disease

or condition resulting in death)

if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated

events resulting in death) Last

29b. Signature and title of certifier

Donna M. Vincenti, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

OCME

Assistant Medical Examiner

(Registrar's Signati

X UNPENDED

Sequentially list conditions,

Edward

1 Burial 2 X Cremation 3 Removal from State

Brinsfield,

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Other Specifi

failure. List only one cause on each line

- For State Registrar		Cei	rtificate o	f Death					Reg. No.			
1. Decedent's Name (First, Mic Suzanne Et	nlev Gar	ner						2. Date of De Month June 15,	Day	Yea		Time of Death 0017 hrs
4a. Facility Name (if not institu				4b. City, Tov	vn, or Lo	cation of	Death		4c.	County o	of Death	
St. Mary's Hospital				Leonard	dtown				s	t. Mary	's	
5. Social Security Number 216-96-1474	6. Sex	7. Age (In yrs. I		If Under Months	1 Year Days	If Under Hours	24Hrs. Min.	8. Date of E	•		Foreign	lace (State or ^{ry} Colorado
Usual Residence of Decedent		1 73						102/02	7130	0		COTOTAGO
10a. State 10b. Count	у	10c. City,	Town or Local	tion							10	d. Inside City Limits
Maryland St. M	lary's	Lexi	ngton E	ark							1	Yes 2 X No
10e. Street and Number				10f. Zip Co	ode				10g. Citiz	en of Wh	at Country	?
20546 Tree To	o Road			20653					Unit	ed S	tates	5
11. Marital Status 1 Never Married 2		cedent Ever in U. forces? 2 X No		es, specify (Cuban, N	Mexican, F		ecify Yes or N Rican, etc.)	0-	14. Race White		n Indian, Black,
3 Widowed 4 X	ivorced If Yes, Give Ye or Dates:	ar	1	Yes 2	No :	specify:				Specify:	Whit	:e
15. Decedent's Education (Sp	ecify only highest gra	de completed)	16a. Deceder	nt's Usual Oc lost of workin					16b. K	ind of Bus	siness/Indu	istry
Elementary/Secondary (0-12	College (1-4 or 5+)	during in	IOSE OF WORKI	ig ille. D	ONOTU	e reur	eu)				
12			Crisis	Couns	selo	r			Cou	ınse1	ing	
Father's Name (First, Midd	le, Last)						Name	(First, Middle,	Maiden	Surname)		
William P. Em	1ev				Δ	udres	, V.	. Voge	i			
19a. Informant's Name/Relatio			19b. Mailin	g Address (ural Route Nu		y or Towr	n, State, Zi	p Code)
William Emley	/Father		19375	Cypre		Ridaa	. т.	rrago	Loc	ahur	~ 17/	20176

Brinsfield-Echols Cre |06/18/2011 |Charlotte Hall, MD

22955 Hollywood Road, Leonardtown, MD

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

June 15, 2011

20650

Approximate Interval Between Onset and

Death

Brinsfield Funeral Home,

Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. 6 pleted Com Be ဥ

Director

Funeral

Physician /Medical Examiner

portant:

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, MD 21215-0036

Examiner signed by the attending physician and I be detached for use as the burial - transit Sa The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 certificate has To the Hospital or Attending Physician: within 24 hours after death. within 24 hours are.

To the Funeral Director: After trus-After this

0				_						
hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 4 Pregnant at time of de	2 Fetal death	3 Ectopic pregna	ancy	23d. Date of de Month	livery Day	Year		
by P	Part II. Other significant conditions	contributing to death but not re	esulting in the underlying o	ause given in Part I.		cco use contribu				
Completed					24a. Was an autopsy performe	prio ed? dea	r to completio	dings available n of cause of		
9	25. Was case referred to medical		26	3.Place of Death (Check	only one)					
O B	examiner? 1 ✓ Yes 2 No	ospital: 1 Inpatient 2	ER/Outpatient 3 DD	A Other Nursin	rrsing Home 5 Residence 6 Other:					
	27. Manner of Death	28a. Date of Injury	28b. Time of Injury 28	c. Injury at Work?	28d, Describe how	injury occurred				
ation	1 Natural 5 Pending 2 Accident Investigatio	(Month, Day, Year) fd 6-14-11	fd 11:21 pm	1 Yes 2 X No	Unknown					
Certification	3 Suicide 6 X Could not b determined	28e. Place of Injury - At ho	ome, farm, street, factory, cidence	28f. Location (Street or Town, State Lexington	∍)20546 T	reetop				
lical C	Check dily	n: To the best of my knowled On the basis of examination a						s)		

29c. License number

O.C.M.E

900 W. Baltimore Street, Baltimore, MD 21223

20b. Place of Disposition (Name of cemetery,

aNarcotic(Oxycodone and Methadone)Intoxication

AMENDED 23a, 27, 28a-f, per me, g918 8-30-11 sm

22. Name and Address of Facility

crematory or other place)

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

DHMH 17 Rev 1/2001 DCME 2006

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 201 3304 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner ambridge If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month Day, yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Days Hours **Director** Usual Reside nce of Decedent 10d. Inside City Limits or 28a-f shov 10a. State 10c. City, Town or Location Important; If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director amb 1 Yes 2 ☐ No 10e. Street and Number 10f, Zip Co 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1

Yes 2 □ No Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify: Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education ď (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 Is marked other than "I Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname ဂ္ permit. Page 1 and 2 should Department of Health and Me 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) ation - City or Town, State 4 Donation 5 Other (Specify) Support of uneral Service Licensee Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate hock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ slioblastone disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? performed Yes 2 2 🗆 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA မှ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work 1 Yes 2 No death. Accident Investigation 24 hours after deat Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the To the C License number 29b. Signature title of ertifie 29d. Date signed (Month, Day, Year) 6.8 person who completed cause of death (Item 23a) (Type, Print) 30. Name and 125 Anna St MD21613 em 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

1-04036 Villiam Greaser			pe or Print i tate of Maryla							egible	201		20	252
		1- For State Registrar			tificate o			, ,		Reg. No.				
Physicia Medical Exami		Decedent's Name (First, Midd William Jose		r		_	-		Date of De Month May 30,	ath	Year		3. Time of D 0941 h	
		4a. Facility Name (if not institution	on, give street and no	ımber)		4b. City, Town, o	or Location		·		. County o	Death		
-		University Hospital				Baltimore	Len	0.00	0.0.4.65			0 B:45	-1 (0)	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs. las		If Under 1 Ye Months Da		Min.		•	ĺ	Foreign		
Director		212-40-8513	1XM 2 F		68 Yrs	S.			Sept.	/, 1	942	Cou	ntry) MI)
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Loca	tion							10d. Inside (City Limits
	L	DE Sus	sex	La	aurel								1 Yes	2 X No
Maryland 28a-f show 1 at once.	Director	10e. Street and Number				10f. Zip Code				10g. Citi.	zen of Wha	at Count	ry?	
the M a or 2		27880 Layton	Road			1995	6				U.S.A	A.		
with ms 23	Funeral	11. Marital Status		cedent Ever in U.S		as Decedent of H				lo-	14. Race - White,		an Indian, B	lack,
death or ite	Ľ	1 Never Married 2 X M	1X Yes	2 No		_			cari, etc.)		vviito,	GIC.	1.1.	
s after	by	3 Widowed 4 Div	orced If Yes, Give Yes	VIELIIA	ш	Yes 2 X N			4. 4		Specify: (ind of Bus	: <i>!</i> !	white	3
2 hour	ted	Elementary/Secondary (0-12)				nt's Usual Occup nost of working lif				IOD. P	and or bus	ii iess/ii i	dustry	
36 hin 72 than edical	Completed	12	00050 (, , , ,		Police	Offi	cer		La	w Eni	forc	ement	
5-00 ed wil fygier other	S	17. Father's Name (First, Middle	, Last)				18.Mother	's Name (F	irst, Middle	Maiden	Surname)			
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Joseph Ignat		er		Elma Mae Hopkins								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ဌ	19a. Informant's Name/Relations		7.6	M.	g Address (Stre						_	Zip Code)	
MD and 2 sho can 27 is		Jan Carol Greater Jan Carol Gr	easer (Wife)		O Layton			oate		19956		own, State	
Ore		1 Burial 2 X Cremation	n 3 Removal fr	om State cr	ematory or ot	ther place)						•	·	
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other S		Cre		of Delm			4 , 201	1 D	elman	r, D	elawan	re
Bal Departi		2)-Signature of Purieral Service	1+ - 1011	1010.	22.	Short Fu	ineral	Home	<u>.</u>		ast (e Stre 19940	eet
Physician		23a. Part I. Enter the disease, or		aused the death. I	Do not enter t	the mode of dying	g, such as c	ardiac or re					Approximat	
Medical (7 ()	failure. Listonly one cause Immediate Cause (Final disease	A 11-	rotic Cardiova	scular Dis	ease							Between C Dea	
Examiner		or condition resulting in death)		consequence of)								$\neg \uparrow$		
	Ļ	Sequentially list conditions,	b.	consequence of)										
	nin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated		consequence or)								0.0		
sd sit	Examiner	events resulting in death) Last	Due to (or as a	consequence of)	:									
executed an and al - transit	- I	LINDENDED	d											
o, e be e: ysiciar burial	edi	UNPENDED IF FEMALE:	AMENDED							100	l D-1			
876 tificat ng ph	N/	23b. Was decedent pregnant in the past 12 months?	ne 23c. if yes,	outcome of pregna pirth		etal death 3	Ectopic	pregnanc	у	230	d. Date of o Month	ielivery Da	ıy	Year
Box 68760, e death certificate be excite a the attending physician ed for use as the burial.	Sici			ant at time of dea	th 5 🗌 O	ther (Specify)								
D. Be	Physician/Medica	Part II. Other significant condit	la - Ouku		sulting in the	underlying cause	given in Pa	ort I	23e Did	tobacco	use contrib	ute to th	e cause of d	leath?
ies that the signed by	<u>a</u>	Renal disease. Chron	_		_		-					_	bly 4 🗸 U	
ords, w require s been sig	Completed					, 		_	24a. Was	an	24b. W	ere auto	psy findings	available
COF law r has b	힏									ormed?	de	eath?	mpletion of o	ause of
tal Rection: The certificate ector, page		25. Was case referred to medica				26 Pine	e of Death	(Chack and	1 Yes	2 N	0 1	✓ Yes	2 _	No
/ital	B	examiner?	Hospital:	Inpatient 2 🗸 E	ER/Outpatient		Other ₄	Nursing H		Reside	nce 6	Other:		
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	<u>۽</u>	1 Yes 2 No 27. Manner of Death	28a. Date	of Injury 2	28b. Time of		ury at Work		3d. Describe			,		
ion tendin for: A	흵	1 Natural 5 Pend	ding	, Day,Year)		1 🗆	Yes 2	No						
VISI or Att fter de Direct			stigation 28e. Plac	e of Injury - At hon	me, farm, stre	et, factory, office	building, et	c. 28	or Town,		nd Number	or Rura	Route Num	nber, City
Di spital cours a filled	Certification:	4 Homicide	rmined (Specify)						or rown,	Jiale)			_	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		Torrow oray	hysician: To the bes											
To the comp	Medical	one) 2 Medical Exa 29b. Signature and title of certifie	miner: On the basis and manner s		u/or irrvestiga		se number	curred at tr	ie ume, date)
	2	235. Signature and title of certifie	51				.M.E.				31, 201		h, Day, Year)	
K.		20 Name and addition of	udea damento de de	a of death floor	220)		VI. L.			Iviay				
10,VA	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223													

State 31. Date filed (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	-	epartment of F Certificate of		·	giene Reg. No	20263
	Dhyoisi	20	1. Decedent's Name (First, Middle, La	ast)				2. Date of De	eath Day Yea	3. Time of Death
	Physici /Medio		LeRoy G. Greenw					June :	3, 2011	9:58 A ^M
	Examin	er	4a. Facility Name (If not institution, gi			4b. City, Town, o		ath	4c. County of De	
-	Funeval		946 West Schuma 5. Social Security Number 6.		urive e (In yrs. last birth	Salis	•	rs. 8. Date of Bir		
П	Funeral Director		351-01-5896	1 XX M 2□F		rs. Months Days	Hours Mi		ay, Year) 17, 1919 II	Birthplace (State or Foreign Country) Linois
	and wo		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maryl f sho	tor	MD Wicomi	60		sbury				1⊠Yes 2□No
	h the	Director	10e. Street and Number		Dail	10f. Zip Code			10g. Citizen of What	Country?
	23a c		946 West Schuma	ker Manor	Drive	2180)4		U.S.	Α.
936	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, it is fledfeal Evariting to use the continuent of the continuent	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 XYes 2 If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	14. Race - Ai Black, Wi Specify:	merican Indian, nite, etc. white
2-0	72 hou natura	eted	15. Decedent's E (Specify only highest gi	Education rade completed)	16a. I	Decedent's Usual Occup (Give kind of work done	pation	vorkina	16b. Kind of Busines	ss/Industry
21215-0036	within giene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5		life. DO NOT use retired	d)	Circing	U.S. G	overnment
	thould be filed and Mental Hygi marked other matic event, II	Be C	17. Father's Name (First, Middle, Las	t)				, .	e, Maiden Surname)	
<u>y</u> la	2 should be finand Mental is marked of raumatic ever	ပို	Roy Greenwood					Bosler		
Maryland	12 s h ar 7 is trau		19a. Informant's Name/Relationship Carolyn T. Green			Mailing Address (Street 6 W. Schuma				
ē,	s f and 2 of Health item 27 i		20a. Method of Disposition	wood (wile	-	Disposition (Name of crematory or other place		Date	20c. Location - City	
m 0	Pages nent of hint: If ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec			orv of Delm	i i	-2011	Delmar, D	elaware
Baltimore,	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Funeral Service Lice	ensee		22. Name and Addre	ss of Facility		bermar, b	Clawara
	205 20		Gry Thort			13 East Gr	ove Str	eet Del		9940
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	nplications that caused y one cause on each lir	Ithe death. Do no ne. -	ot enter the mode of dyi	ng, such as card	iac or respiratory a	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. ASCVI	a consequence of	n.				
7	Examiner		Sequentially list conditions	b. #1570	RV OF	PROSTATE (ANCER			1
	ted nsit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Divisito (or as	a consequence of					
Ć,	execunation and ial-tra	Exar	that initiated events resulting in death) Last	c	a consequence of	n):				
68760,	ifficate be executed g physician and as the burial-transit	edical		d. HYPE	RLIPIDEM	/A				
			IF FEMALE:	23c. If yes, outcome	of pregnancy					
O. Box	The law requires that the death certi ate has been signed by the attending age 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		2 Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	У		23d. Date of Month	Day Year
σ.	that the dended by the detached		9 ☐ Unknown Part II. Other significant conditions		ut not resulting in	the underlying cause give	en in Part I	23e Did	tohacco use contribute	e to the cause of death?
of Vital Records,	quires t en signe uld be c	ed by		oonanouting to death o			ciriir arti.		/	Probably 4 Unknown
eco	e law requir has been si je 2 should l	Completed						24a. Was		autopsy findings available to completion of cause of
<u>~</u>		Con						perf	ormed?/ death	es 2 □No
Vita	Physician: this certific	Be	25. Was case referred to medical examiner?	Hospital:				eath (Check only		
of	Physral di	: To	1 Yes 2 No 27. Manper of Death	1 ☐ Inpatie		patient 3 DOA Oth	4 LI Nursing		how injury occurred	pecify)
ion	nding I ath. :: After e funer	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y, Year) In	jury Wor	ḱ? Yes 2 □ No	EGG. DGGGHDG	non injury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not determined	28e. Place of Inju	ury - At home, fari c. (Specify)	m, street, factory, office		28f. Location City or To	(Street and Number or wn, State)	Rural Route Number,
	ne Hospital 24 hours a le Funeral bletely filled	Medical	29a. Certifier 1 Certifying F (Check only one) 1 Medical Example 1	Physician: To the best aminer: On the basis o and manner sta	f examination and	death occurred at the till/or investigation, in my	ime, date and place opinion, death o	ace, and due to the ccurred at the time	e cause(s) and manne , date and place, and o	r as stated. due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mo	onth, Day, Year)
	181		July M	0.		05	0929		6-3-	//
	117.18		30. Name and address of person who	-				0:		
e _j	Sta	te	31. Date filed (Month, Day, Year)		ISRURY ar's Signature	MO 218	07 ->	0y LR	JW19	
	Registr		31. Date filed (Month, Day, Year)	1 /2	1 1	redo				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011June РМ 2350 Leslie Mitchell Gilbert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil E1kton Union Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** NOV 22. 1939 1 🕅 M 2 🗆 F West Virginia 221-24-9945 71 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show odical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗆 Yes 2 😾 No E1kton Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 40 A Pine Bluff Lane 21921 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status orces? N1956-Armed Forces? 1 Never Married 2 Married 1 X Yes Maryland 21215-0036 1960 1 ☐ Yes 2 🗓 No Specify: Specify: 3 Widowed 4 X Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical Eonce. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Automobile Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ethel Taylor Richard Gilbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1191 Shady Beach Rd., Elkton, Leslie M. Gilbert, Jr./Son MD21921 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 20. 1 A Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Rose Bank Cemetery Calvert, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician, Zucer ration disease or condition resulting in death) Medical Due to (or as a consequence of) Examine neumonia Sequentially list conditions, it any, has any to immediate cause. Enter Underlying Examiner Due to or as a fonsi quence of that the death certificate be executed attending physiclan and I for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No detached for Day 5 Other (specify) Year Pregnant at time of death 1 Yes 2 Unknown the P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Curcer Fibrillation page 2 should be To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 🔀 Inpatient 2 🗀 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of ceptitie 29d. Date signed (Month, Day, Year) 15 Gopez MA Carlo E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 Elkton

~ The del

3 00 31. Date filed (Month, Day, Year) Street

32. Registrar's Signature

11-04128 Blaine Franklin Heller

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			Certific	ate of	Death				Re	eg. No.			
Physicia	an/	1. Decedent's Name (First, Midd] .]		Цел	ler			2.	Date of Dea Month	th Day	Year		3. Time of Death
Medical Exami	ner	Blaine		ankli	rı						June 2, 20	011			0802 hrs
		4a. Facility Name (if not institution 14316 Old Old Town I		umber)		4	b. City, Town Old Tow		ocation of	f Death			County of egany	Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In	yrs. last bir	thday)	If Under 1		If Under	24Hrs.	8. Date of Bir			9. Birti	hplace (State or
Director		215-82-8881	1 ∏ M 2☐F	50		Yrs.	Months	Days	Hours	Min.	09/10	/196	0		n Maryland
	H	Usual Residence of Decedent	·	l .			LL	_					_		
any		10a. State 10b. County	·	10c.	City, Town			,							10d. Inside City Limits
nd show	٦	MD A1	legany			Cumb	erlan	d							1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	A				10f. Zip Coo	le	-	2150	2 1	0g. Citize	n of Wha	t Coun	try? Δ
ifie P	ā	20 Blackist	Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-												
h with	Funeral	11. Marital Status											4. Race - White,		can Indian, Black,
L -	필	1 Yes 2 No													
s afte	۵	3 Widowed 4 Noise 15. Decedent's Education (Spe	orced If Yes, Give Ye or Dates:		nd) 16a		Yes 2 X			ind of wor	k done		Specify: White D. Kind of Business/Industry		
2 hour	ted	Elementary/Secondary (0-12)		1-4 or 5+)	10a.		st of working					TOD. Kil	id or bus	11033/11	iddail y
0036 within 7; jenc. mer than	Completed	12		,			Machin	ist	t				Railroad		
other M	녌	17. Father's Name (First, Middle,	Last)					18	3.Mother's	Name (F	irst, Middle, M	Maiden S	urname)		•
21215-0036 ould be filed within 7 if Mental Hygiene. I marked other than ie event, the Medica	BB	Robert	Victo	r		Helle				talie			Jean		Meir
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Inst: If trem 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	٩	19a. Informant's Name/Relations									al Route Num				Zip Code)
MD and 2 showalth and 2 showard and 27 is raumating		Michael Coffma 20a, Method of Disposition	an / Nepn				ion (Name o			•	dtown,				Town, State
Ore, of He If ite		1 Burial 2 Cremation	n 3 Removal t		cremat	ory or other	er place)							•	
im Page ment tant:	ļ		Donation 5 Other Specify: Cumberland Crematory 06/05								05/2011 Cumberland, MD ms Family Funeral Home, P.A.				
Baltimore, MD permit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumat		21. Signature of Funeral Service	Licensee									·			21502
Physician	-	23a. Part L. Enter the disease, or	complications that	caused the c	leath. Do no										Approximate Interval
Medical		failure. List only one cause	on each line.				,				,	,	,		Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Acute Cor Due to (or as			IIDUS								_	
		Sequentially list conditions,	b. Atheroscle	rotic Car	diovascu	lar Dise	ase								
	<u><u>e</u></u>	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequer	nce of):										
	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequer	nce of):										
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit			d												
760, icate be execut physician and the burial - tra	/Medical	UNPENDED	AMENDED												
760, ficate be g physic the bur	W.	IF FEMALE: 23b. Was decedent pregnant in the		outcome of birth			ıl death	3 [Estania	pregnanc			Date of d		ay Year
Sox 68' leath certifi e attending I for use as	clar	past 12 months?		nant at time			er (Specify)	3	Lctopic	pregnanc	y	14	OTILLT	0	ay real
Box 68 e death certif the attending ted for use as	Physiciar	1 Yes 2 No 9 Uni	Known 9 Unkr	nown			J. (
ires that the signed by the detached	D P	Part II. Other significant condit	ions contributing	to death but	not resultin	g in the ur	derlying cau	se giv	en in Par	t I.					he cause of death?
B, P ires ti signe d be d			_								1 Yes	2 !			ably 4 🗹 Unknown
ords w requir	Set										24a. Was autop	sy	pri	or to co	opsy findings available ompletion of cause of
Reco	Completed										1 Yes	med? 2 No		ath? ✔ Yes	2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medica examiner?					26.P			Check on!	y one)				
	P	1 ✓ Yes 2 No	Hospital: 1	Inpatient :		utpatient						Residenc			Scene
ding Ph	I	27. Manner of Death 1 ✓ Natural 5 Pend		of Injury h, Day,Year)	28b.	Time of In	· _		at Work?		3d. Describe h	now injury	occurre	d	
SiOr Attence death cctor:	cati	- J Felic	stigation	1-:	At 1						M I acation (6	`* *	I Niversia au	D.	al Route Number, City
Divi	Certification	dete	d not be 20e, Fla	ce of Injury - 1	At nome, to	arm, street	, lactory, om	be buil	iding, etc	. 20	or Town, S		i Mattipet	or Rui	ar Route Number, City
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /		29a. Certifier 1 Certifier Pl	hysician: To the be		wledge de	ath occum	ed at the time	e. date	and place	ce, and di	e to the caus	e(s) and	manner a	s state	d
thin 2, the F	Medical	Contour only	miner:On the basis	of examinat											
T is in	₹	29b. Signature and title of certifie	and manner	orateu.			29c. Lic	ense r	number			29d. Da	ite signe	(Mon	th, Day, Year)
		Pot An	om	-Pal	00 ch	6.0	0.	C.M.	.E.			June	3, 201	1	
(3000	ŀ	30. Name and address of person				- 66							-		
MS		Patricia Aronica-Pollal				niner 9	00 W. Ba	ltimo	ore Stre	eet, Bal	timore, MI	2122	3		
Sta Regist		31. Date filed (Month, Day, Year)		tegistrar's Si	gnature	red									
Regist	للثان														

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Vaughn Frank Hammond JUNC 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner NICANICO If Under 1 Year If Under 24 H/s 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday, Funeral Months (Month, Day, Year, 1935 1 XM 2 - F Director 217-36-0176 76 MD Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2 X No MD Wicomico Willards 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 36440 Mt. Pleasant Rd. 21874 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traument. Farmer Farming 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clyde F. Hammond Margaret Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Harriette Hammond 36440 Mt. Pleasant Rd., Willards, MD 21874 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Mt. 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Cem. 6/11/2011 Willards, MD f Funeral Service L 22. Name and Address of Facility Burbage Funeral Home MD 21811 108 William St., Berlin, 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phylician/ RESPIRATORY NORONE (ARDS disease or condition SEKS Medical resulting in death) Due to (or as a consequence of): **Examiner** ETC VALLE REPLACEMENT A WEEKS Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit SENUSIS 27C that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes ∠ ∟ 9 ☐ Unknown 9 Hnknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CONGESTIVE HEART FALURE 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records, Were autopsy findings available prior to completion of cause of death? 24a. Was an RENT INSFALLANCY autopsy performed? this certificate 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 힏 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 14 Natural 5 Pending 1 ☐ Yes 2 ☐ No M Investigation 2 Accident 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital or 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of ce 1 53551

State Registrar

D1 HA

30. Name and addre

Tames

31. Date filed (Month, Day, Vear)

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CATTOI

who completed cause of death (Item 23a) (Type, Print)

100

11-04437 Blaine D. Hendericks

Plea

ase Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	20267
State of Maryland / Department of Fleath and Mental Hygiene	

	1- For State Registrar		Certificate o	oi Deain	Nog. No.						
Physician/ Medical Examiner	Decedent's Name (First, Midd							Date of De Month June 12,	Day 2011	Year	3. Time of Death 2349 hrs
	4a. Facility Name (if not institution 123 Appletree Lane	on, give street and number)		4b. City, To		cation of D	eath			County of Dea ince Georg	
Funeral Director	5. Social Security Number 578–92–7996	6. Sex 7. Age (In	yrs. last birthday)	If Under Months	1 Year Days	If Under 24 Hours	4Hrs. Min.	8. Date of B		Fore	irthplace (State or ign country)
r any	Usual Residence of Decedent 10a, State 10b, County	10c.	City, Town or Loc	ation		l					10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 23a-f show notified at once. al Director	MD Prin	ce Georges	Oxon H	10f. Zip C				Т	_	en of What Co USA	
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Baltimore, Permit. Pages l and Department of Heal Important: If item injury or other tra	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other S	n 3 Removal from State	20b. Place of Disp crematory or Atlantic	other place)				Date 5/2011		n Burn	ie, Md
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To the within 2 To the complet	29b. Signature and title of certification of the ce	and manner stated.		29c.	License n	number			29d. D		donth, Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Miriam Lorraine Hubka AM 00 ZOII Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death coasta) the Pice Dicomico Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Days 235-40-7439 84 Director 03/22/1927 West Virginia Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 Yes 2 X No 0e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 145 Francis Drive 21804 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married and 2 should be filed within 72 hours after of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give 3 Widowed 4 X Divorced Specify. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cyrus T. Lipscomb Radie Kiester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code) 1120 N. Clark St., West Hollywood, CA 90069 Diane E. Hubka/daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 6/10/2011 Salisbury, MD ture of Funeral Service Licensee HOIloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CRREBROVASCULAR ACCIDENT disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 nonths? Pregnant at time of death Month Day Year 1 Yes 21 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2/☐No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law 124 hours after death.
Funeral Director: After this certificate has t autopsy perform 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence (C) Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 2 🗌 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO05 8410 -011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1300 33 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Hub

32/Registrar's Signatur

	_	state amendeditem	n#1-wchd-te	-6/6/1 c e	rtificate of	Death		Reg. No.	
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288-	Director	10e. Street and Number	0 1-	7 40.1211	10f. Zip Code			10g. Citizen of What Co	ountry?
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Funeral Director. ely filled in by the	edicai	29a. Certifier 1 Certifying Phy 2 Medical Exam	iner: On the basis of ex	kamination and/or i	nvestigation, in my 29c. Licer	opinion, death occi	urred at the time.	date and place, and di 29d. Date signed (Mo.	ue to the cause(s)
To the Funeral Director: After thi completely filled in by the funeral	edicai	29a. Certifier 1 Certifying Phy 2 Medical Exam	iner: On the basis of earlier state Khah L completed cause of dear	M	29c. Licer	opinion, death occi nse number 38647	Sazis Bu	29d. Date signed (Mo	nth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ C:42AM 2011 <u>Cruikshank Hill</u> Thomas Jr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbur comico 04 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** 6-8-1921 Days Months Min Maryland 225-12-0963 Director 89 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is anawled other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Tes 2 X No Wicomico Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21801 USA 611 Tressler Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 X Yes 2 No 1943—
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed Year or Dates 1950 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Medical College (1-4 or 5+) Elementary/Seconday (0-12) Own Practive Internest 5+ Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Adaline Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37 Park Avenue, White Plains, New York 10607 Sarah Hill - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunny Ridge Mem. Pk. 6-8-2011 Crisfield, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home E. Main Street, Salisbury, Maryland 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Certer year disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a sunsequence of): If any, leading to immediate cause. Enter Underlying that the death certificate be executed Cause (Disease or linjury that initiated events for use as the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal de
4 Pregnant at time of deat 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No ed by the a Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 No 3 Probably 4 Unknown Records, Physician: The law requires page 2 should 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy certificate 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certific; completed filled in by the funeral director, 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) HOS Pic 1 \(\text{Yes} 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗷 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (E 06-04-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NA GREGORIO LOSO 5302 CHINABERRY DRIVE SALISBURY, MD 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar Amend Items State of Mary land / Department of Health at Certificate of Death	rs/Zortahl	ygiene Reg. No.	1 20271
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Division of Vital Records, P.O. Box 687	res tha signed	d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATTRIBLE ATTRIBUTE ATT			tribute to the cause of death? 3 □ Probably 4 □ Unknown
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	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ploompleted filled in by the funeral director, page 2 should be detached for use as to complete the second of the funeral director.	Medical	Family Dollar Store 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and pla	ice, and due to the d	ause(s) and mann	ner as stated.
	thin 24 the Ft the Ft mplete	Mec	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date an	urred at the time, date and place, and due to	he cause(s) and m	nanner as stated.
	5		29b. Signature and title of certifier 29c. License number 25c. License number		- 4	7/2011
	De		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		-/	12011
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	Stat Registra	e ar	31. Date filed (Marth Day Year)		,	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #12, nls, per FD, 06/06/11, Allegany Co. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** 3:50 AM HAROLD JUNIOR JEWELL 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner THE LIONS CENTER CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/22/1928 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. WEST VIRGINIA 1 ★ M 2 🗆 F 82 Director 212-24-1561 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Examinar mast be reciffied at Director 1 ☐ Yes 2 ☑ No MD ALLEGANY CUMBERLAND 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 901 SETON DRIVE 21502 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Kores 14 Race - American Indian 11. Marital Status ^{rces?} Korean ^{2□No} Conflict 1 Yes 2 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: þ Specify: WHITE 3 Widowed 4 Divorced Year or Dates: -WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) KELLY-SPRINGFIELD Elementary/Secondary (0-12) 12 College (1-4or 5+) SECURITY GUARD TIRE COMPANY Department of Health and Mental Hygis Important: If item 27 Is marked other i any injury or other traumatic event, It once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES HAROLD JEWELL BEATRICE FAYE SHANHOLTZ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1408 HAMILTON BOULEVARD, HAGERSTOWN, MD 21742 / SON REV. RICHARD H. JEWELL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CUMBERLAND CREMATORY: 06/06/2011 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND, MD 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. re of Funeral Senfice Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 202 GREENE STREET, CUMBERLAND, MD 21502 Immediate Cause (Final **Physician** ourta disease or condition resulting in death) /Medical Due to (or as a consiquence of): Examiner 5.C. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No 2**X** No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 Wo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 □Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6-4-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Broadwar Town Mr trostburg 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUN 0 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ^{Day} 2011 Bertha Johnson 12 5:30 p.nl√ Medical June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 42502 Keith Court St. Mary's Hollywood 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Days Hours Mary land 02/03/1920 **Director** Yrs 216-12-4347 91 Usual Residence of Decedent 28a-f show 10b. County 10a. State with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No Maryland St. Mary's Loveville ms 23a or must be r 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral <u>26265 Loveville Road</u> 20656 ral", or items ! <u>United States</u> death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 □ Divorced "natural" Completed Specify. Year or Dates Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Samuel Kane Laura Beale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Gunn/Son 42502 Keith Court, Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or conce. cemetery, crematory or other place. XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Queen of Peace Cem 06/17/2011 | Helen, Maryland 21. Signal of Fureral Service Licensee Edward N. Brinsf 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfi 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph_sician/ Medical Due to (or as a c Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy ó Month Day Pregnant at time of death Year detached the 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No **Director:** After this certificate of in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 4 Nursing Home 5 Residence 6 X Other (Specify) Residence မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending hours after death 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

A

State

30. Name and address 9

Jennifer & Chmidt

40900 Merchants Lane, Suite 205, Leonardtown, MD

erson who completed cause of death (Item 23a) (Type, Print)

32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieme Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** June 7, 0520 Florence M. Jones 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Harrison Senior Living Nursing & Rehab. Ctr. Snow Hill If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 2, 1924 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Country) Hours 1 M 2 F 215-26-2709 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 XNo Funeral Director Princess Anne MD Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11318 Greenwood School Road 21853 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black ģ 3 NWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Inc 6th Laborer Campbell Soup Co., 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (ပ Sarah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 702 - Fruitland, Maryland 21826 Ronald Deal/ Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Princess Anne, MD John Wesley Cemetery June 11, 4 □ Donation 5 Other (Specify) 21. Signature neral Service License 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause of each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** - month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence bi). Examine Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 **N**0 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 1 Inpatient ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Sectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours aft

To the Funeral Di

completely filled in

31. Date filed (Month, Day, Year) State Jud 19 **201** Registrar

29b. Signature and title of certifier

SARAD R. BARAL, MD

29c. License number

29d. Date signed (Month, Day, Year)

6,7,2011

30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 604-Market 17. Poconoke

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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2	10		30. Name and addr	ress of person who	completed cause of	death (Item	23а) (Туре,	Print)	1	- /		7-4	16		-
0	·		William	H. Rol	sins. M.	D. 0	200	Civic .	Ave.	Sal	isbu	- TUIN	130	21804	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar amended item#20b-wchd-te-6/Gertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sol Richard June 4, Physician/ Jacobs 5:39 a^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico 27017 Osprey Circle Hebron 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🏝 M 2 🗆 F Days Min. Hours 92 1070971918 New York Director 082-07-8774 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural". or items 23a مت 200ء فصم 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland Wicomico Hebron 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27017 Osprey Circle 21830 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 Ⅺ Yes 2 □ No
If Yes, Give
Year or Dates. Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jack Jacobs Sarah Rappaport 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27017 Osprey Circle, Hebron, MD 21830 Karen Jacobs/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 6/7/2011 Salisbury, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) CKD To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and I for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year ate has been signed by the page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş Q Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medica æ 26. Place of Death (Check only one) Certificate: To 2 **N**O 1 🔲 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director; After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? ☐ Accident ☐ Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 | Medical Examiner: On the basis of examination and/or investigation, in this opinion, uean occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 057951 06/07/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbany MD21804 504B 106 Milford 31. Date filed (Mont) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Just 01:04 M 2011 Jones Catherine Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death. AICONICO ·g/anol 6. Sex If Under 1 Year If Under 24 H/s 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🏋 F (Month, Day, Year - 22-1928 Hours Min. Country) Maryland Yrs. Director 215-80-6889 Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No MD Wicomico Willards 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5227 Archie Jones Road 21874 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married 72 hours after Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Specify. 3 √ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture 8 Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Powe11 Lydia Timmons Grav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 5229 Archie Jones Road, Willards, Maryland 21874 Arthur F. Jones - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Chur. Cem 6-9-2011 Willards, Maryland 21. Signature of Funeral Service Li€ensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ DIFFICILE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): -transit Exami requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burial-1 Physician/Medical attending physic I for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 D No 3 Ectopic pregnancy 5 Other (specify) ____ Month Year Day Pregnant at time of death 1 ☐ Yes ∠ q 9 ☐ Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? page 2 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending s after death.

I Director: Aff Accident
Suicide
Homicide 1 Yes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital within 24 hours To the Funeral I Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 EASTERN

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician May Heather 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 0513011985 Maryland 1 □ M 2 🛣 F 26 Yrs **Director** 219-08-1600 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 X No Director Salisbury Maryland Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō 23a USA Funeral 21801 6316 Rockawalkin Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 ō 1 Yes 2 No If Yes, Give Year or Dates: Specify þ Specify: 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education : If Item 27 Is marked other than "natu or other traumatic event, the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Student 12 College Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lisa Gordy မ Jeffrey Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6316 Rockawalkin Rd., Salisbury, Maryland 21801 Jeffrey Jones father Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Wicomico Memorial Department o Important: If any injury or once 06 06 2011 | Salisbury, Maryland ☐ Donation 5 ☐ Other (Specify) Holloway Funeral Home P.A. (501 Snow Hill Rd., Salisbury, Maryland 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) elsis /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner sequence of Due to (or as a co or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy $1 \ \square \ \text{Live birth} \qquad 2 \ \square \ \text{Fetal death} \\ 4 \ \square \ \text{Pregnant at time of death}$ 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 \sum Nursing Home Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of . Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 No 2 Accident Director: / Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Box 68760. P.O. Division of Vital Records. within 24 hours a

Medi

State Registrar

FS-000 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287

1/11 go /is 31. Date filed (Month, Day

29b. Signature and title of certifier

and manner stated.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 | amend Item# 30 per DVR, g916 6-24-1 sm State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death , 2011 BARBARA CONSTANCE JOHNSON JUNE 17 7:00A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CHESAPEAKE SHORES N.H. LEXINGTON PARK ST.MARY'S 5. Social Security Number 8. Date of Birth 8-19-1935 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 □ M 2 😿 F Days Hours 214-58-0838 ENGLAND 75 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits CHARLES LA PLATA 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6265 ARCHDALE PLACE 20646 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 X Married If Yes, Give 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) McCULLEY'S AIR Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY CONDITIONING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HERBERT JAMES MITCHELL ELSIE BUSBY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEFFREY JOHNSON-SPOUSE 6265 ARCHDALE PLACE LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD. VETERANS CEM. 6-23-11 CHELTENHAM, MD. Signature of Funeral Service License MO0479 2. Name and Address of Facility
RAYMOND FUNERAL SER
LA PLATA, MARYLAND 2 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final VASUULAR Cerebra disease or condition resulting in death) Due to (or as a consequence of): R sided Heniplea FLUMON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 menths?

1 Yes 2 No
9 Unknown Ectopic pregnancy 5 Other (specify) Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy OCUYX performed 2 🗆 No 1 🔲 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at

1 Yes 2 No

Fort Washington, MD, 20744

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

501

Physician/ Medical Examiner Examine

Physician/

Medical

10a. State

MD.

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Director

Funeral

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Completed

Be

Examiner

Funeral

Director

or 28a-f show

23a

items

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72 hours after

permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than '

Maryland 21215-0036

Baltimore,

any injury or other traumatic event, the Medical Examiner must be notified at

the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed þ ate has been signed! page 2 should be det this certificate has

Physician/Medical

Completed by

Be

Certificate: To

Medical

IF FEMALE:

examiner?

1 Natural

3 Suicide

29a. Certifier

(Check

<u>Samuel</u>

only one)

4 Homicide

Accident

5 Pending

and title of certifie

Kleiman

30. Name and address of person who

Investigation

determined

6 Could not be

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Division of Vital Records, P.O. Box 68760

To the I P &

State

Rd.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

mpleted cause of death (Item 23a) (Type, Print)

Livingston

11701

32. Rec

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 05/31/1 Year Kiah, Jr Lee Herbert 21:26 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Elkton Union Hospital Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 **X**M 2 □ F Days Hours Country) Halifax 243-86-3744 (Month, Day, 60 795C Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1x Yes 2 ☐ No Philadelphia Philadelphi PA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1744 N. Lindenwood Street 19131 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Blk "natural", 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Us Mint Diesetter Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Betty Mae Lassiter ၉ Herbert Lee Kiah, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1744 N. Lindenwood St. Phila PA 19131 Elizabeth Kiah 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 06/07/11 Phila Ivy Hill Crematory PA 4 ☐ Donation 5 ☐ Other (Specify) Chestertown, High St. 2162 21. Signature of Funeral Service Lie 22. Name and Address of Facility 855 Bennie Smith FH 21620 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) r as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami ending physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 🗌 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis or examination and/on investigation, in my opinion, seal occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10, Day 2011 Lorraine W. Kohnen June 1:30 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Columbia Howard If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months. Dec 15, 1919 Missouri **Director** 453-14-3482 91 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10201 Maplewood Drive 21042 United States 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Force 2 1 Never Married 2 Married Yes X No 1 Yes X No Specify: If Yes, Give Specify: White 3 Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Ortlev Edith Wherrett Louise Swanson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a John N. Kohnen/son 2004 Hunters Run Hoover, Alabama 35244 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place Southern Heritage Ceme 6/17/2011 | Birmingham, Alabama 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc ature of Funeral Service Licenses M00957 4112 Old Columbia Pike Ellicott City, MD 21043 Thomas 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ AASTROINTES disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): and -transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical that the death certificate be attending p IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 1 Yes 2 No 9 Unknown ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORONARY ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed Yes 2 Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) nin 24 hours after death.

the Funeral Director: After thin pleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accider 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F 29b. Signature and title of certifie D64395 JUNE 10, 2011 6336 CEDAR LANE COLUMBIA, MO 21044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

DANIEUE

Baltimore, Maryland 21215-0036

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Box

P.O.

Records,

Division of Vital

DOBERMAN, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Linda W. Kittlitz 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Salisbury Rehabilitation a Nursing Cts 5. Social Security Number 6. Sex _ 17. Age (In yrs. last birthday Wicomica isbuc 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🗴 F Delaware Director 221-26-9024 69 Usual Residence of Decedent 23a or 28a-f show Shoun ov.and Mental Hygiene.
I smarked other than "natural", or items 23a or 28a-f shov death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DE Laurel Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 10175 Marvil Drive 19956 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within Medical Transcriptionist Medical Be 18. Mother's Name (First, Middle, Maiden Sumame)
Thelma Lucas 17. Father's Name (First, Middle, Last) ပ္ John F. Watkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 10175 Marvil Drive Laurel, Delaware 19956 Theresa Kittlitz (daughter) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Delmar, Delaware Crematory of Delmarva May 6, 2011 4 Donation 5 Other (Specify) 700 West Street 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hannigan,Short,Disharoon F.H.Laurel, De. 19956 -Hannican 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ 2 disease or condition Medical resulting in death) Ducto (or as a consequence of): Examiner 0 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a conseque/ice of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: been signed by the attending should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy 1 🗌 Yes 2 🗎 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 No Other: မြ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No Natural 5 Pending within 24 hours after death.

To the Funeral Director; Af
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🖹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Wasil Karasik 0540 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death isbury Rehabilitation & Nursing C Vicomic 8. Date of Birth (Month, Day, Year) 11/20/1920 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 **X** M 2 □ F Days 114-22-9192 **Director** 90 Yrs. New Jersev Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Wicomico Salisbury Maryland 1 X Yes 2 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 100 Civic Ave. 21804 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 K No If Yes, Give Year or Dates. þ 1 Never Married 2 Married 1 Yes 2 X No Specify. Completed 3X Widowed 4 Divorced Specify white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Produce Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Karasik Anna (unknown) 19a. Informant's Name/Relationship (Type, Print)
William Karasik/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, PO Box 45, Delaware, NJ 07833 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, cremetory or other North Hardyston Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/8/2011 Hardyston Twp, NJ 21. Signature of Funeral Service License 22 Name and Address Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 0000 Medical resulting in death) Due to for as a conse Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Dile to or consequence of attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ signed by the atte in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 10 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate t completed filled in by the funeral director, page 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending injury 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 2ga. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year)

- 12

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Robins

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2:36 PM Virginia Jackson Lee Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Doctor's Community Hospital Lanham 8. Date of Birth (Month, Day, Year) April 9, 1941 If Under 1 Year If Under 24 Hrs Funeral Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🔼 F Months Days Hours 70 New York Director 052-32-0966 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Suitland Maryland | Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20746 United States 3802 Walnut Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 Never Married 2 Married Specify: Black If Yes, Give 1 ☐ Yes 2 A No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Accountant Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Emma Farrell Gus Osborne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3802 Walnut Lane Suitland, Maryland James W. Lee - Husband Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1.5 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Amityville, New York 4 ☐ Donation 5 ☐ Other (Specify) Amityville Cemetery 21. Signature of Fun Service Lio 22. Name and Address of Facility Stewart Funeral Home, 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed
24 hours after death.
 Funeral Director. After this certificate has been signed by the attending physician and
eled filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Thinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 . ER/Outpatient 3 DOA 27. Manner of Beath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated MDD 58182

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DHMH 17 Rev 7/2009

Registrar

CECIL

31. Date filed (Month, Day,

7500 HADOVER PARKWAY SUITE 101A GREENBELT,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

GEONGE M.D.

Amı 11-04472 Michael William I	Lan	g, Jr Si	t .Mary's, pe or Print i tate of Maryl	n Black In and / Depa	rtment of	f Health and						20285	
Di did		1- For State Registrar 1. Decedent's Name (First, Midd	llo Laet)	Cer	tificate of	Death		12 5	Reg	g. No.		3. Time of Death	
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Funeral Director		5. Social Security Number 6. Sex 7. Age (I			ast birthday)	If Under 1 Year If Under 24Hrs. Months Days Hours Min.			Date of Birth	(MM/DD/YY	Foreig	hplace (State or	
Director		212-36-2209 Usual Residence of Decedent	7	1 Yrs					1/1937 Co		^{intry} Maryland		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland opermit of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other tranmatic event, the Medical Examiner must be notified at once.	10 8								al Route Number, City or Town, State, Zip Code)				
MD and 2 sho alth and m 27 is		Lisa Knight / 20a. Method of Disposition	Daughter	Look		3 Sotter		., H	Hollywood, MD 20636 Date 20c. Location - City or Town, State				
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Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease											
		or condition resulting in death) Due to (or as a consequence of): b.											
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Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be as after death. 31 Director: After this certificate has been signed by the attending physicited in by the funeral director, page 2 should be detached for use as the burn		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day										ay Year	
of Vital Records, P.O. Box 68 ing Physician: The law requires that the death certif After this certificate has been signed by the attending tuneral director, page 2 should be detached for use as	Sicia	past 12 months? 4 Pregnant at time of death The standard of the standard of											
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Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical Ce	4 Homicide (Specify) 29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
To with		29b. Signature and title of certific	29c. License number				29d. Date signed (Month, Day, Year)						
		N-"UL	O.C.M.E.				June 15, 2011						
		30. Name and address of person Donna M. Vincenti, M	_ '	se of death (Item Medical Exan		W. Baltimore	Street, Bal	Itimore	. MD 212	23			
Sta	ate	31. Date filed (Month, Day, Year)	2. R	egistrar's Signatu	ire .				,	_			
Regist	rar	JUN 2 1 2	011 Same	ve B.	park	9							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ GEORGE DELBERT MYERS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Allegany Cumber1and Western MD Regional Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗓 M 2 🗆 F Days Director West Virginia 232-60-7363 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes XX No Fort Ashby Mineral WV 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral U.S.A. 26719 Route 2, Box 377 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status ?7 is marked other than "natural", or iter traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced '62-'64 White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Ironworker & Contractor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha L. Simpson Eugene George Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 2, Box 377, Fort Ashby, WV James Myers / Brother item 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or of ౼ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Ashby Cemetery 106/04/2011 Fort Ashby, WV 22. Name and Address of FacilityUpchurch Funeral Home, Inc. 21. Signature of Funeral Service Licer P.O. Box 1260, Fort Ashby, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Prysician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician Physician/Medical P.O. Box 68760 as the t IF FEMALE use 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy ned by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de by Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗆 Yes 2 🗆 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🔀 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0067876 06 1021 audion & Cher

State Registrar

NLS

Millowbrook Rd, Cumberland, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manhay K. Chenchugalla - 1,2501

Chenchugalla

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month May 27, 2011 01:00 AM M Francis Eugene Miller 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Allegany Frostburg 158 Maple Street 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 1 M 2 □ F Months Days Hours May 13, 1935 Maryland 76 219-34-6074 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 □ No Frostburg Maryland Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 158 Maple Street U.S.A. 21532-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. Affiled Forces: 1 Xiyes 2 □ No If Yes, Give Year or Dates: WW. II 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Trucking Transportation** Machinist 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Small Henry Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21532-Maryland Eleanor Miller wife 158 Maple Street Frostburg 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 MCremation 3 ☐ Removal from State May 28, 2011 Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) **Cumberland Crematory** 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Approximate Interval Between Onset and Death 3 MoS 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Garric Carcinoma Metastahz disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to or as a conse mence of that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an

Physician /Medical **Examiner**

Physician

/Medical

Director

Funeral

þ

Completed

Be

2

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be refulled at once.

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

use as the burial-trans and attending physician ф cate has been signed by the page 2 should be detached certificate has director, this (

Examiner The law requires that the death certificate be executed Physician/Medical ≥ Completed Attending Physician: Be Certification: To funeral After r death. spital or Attendi nours after death. neral Director: A

To the Hospital within 24 hours a To the Funeral C completely filled

in the past 12 months? 1 Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. autopsy performed?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Vagneni

Seton Drive Cumberland, MD 21502

State Registrar

Medical

29b. Signature and title of certifier

Registrar's Signature 32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 27, 2011 John Frve Morton 3:40A Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Frostburg Frostburg Village Nursing Home 5. Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpiaco (Country) MD **Funeral** Hours Min Nov 30 1 M 2 D F ^{")}19<u>25</u> 85 Director 215-20-5149 Usual Residence of Decede ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 □X√es 2 □ No MD LaVale Allegany 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21502 USA 714 Miller Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Completed 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event than "ns (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) banking banker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Morton
19a. Informant's Name/Relationship (Type, Print) Anna Belle Frye Morton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Morton
20a. Method of Disposition MD 21502 714 Miller Street LaVale wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Carcanation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/31/2011 Rocky Gap Veterans Cemetery Flintstone MDSignature of Funeral Service Licenses ^{22. Nam}Scarpeili Funeral Home, PA Ham 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition monas Medical resulting in death) D e to (or as a consequence f) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed Yes 2 ours after death. eral Director: After this certificate I filled in by the funeral director, pag 2 No 1 Ves 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D21244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus Tan M.D 31. Date filed (Month, Dav. Year) 4 Broadway Street Frostburg MD 21532 32. Registrar's Signature State Registrar

11-04377

effrey Floyd Mo	rris	on State of Maryland /						2011	21200
		1- For State Registrar	Cert	ificate of D	eath			eg. No.	
Physici ledical Exami		1. Decedent's Name (First, Middle,Last) Jeffrey Floyd Morrison					2. Date of Dea Month June 10, 2	Day Year	3. Time of Death 1519 hrs
**************************************		4a. Facility Name (if not institution, give street and number)		4b. (City, Town, or L	ocation of Deat		4c. County of Deat	h
	- A.	University Hospital			altimore			Baltimo	
Funeral Director			(In yrs. las	N	Under 1 Year flonths Days	If Under 24Hr Hours Mi	s. 8. Date of Bi	rth(MM/DD/YYYY) 9. Bi	rthplace (State or gr Washington ountry)
J. Ooto		218-06-6324 1X M 2 F Usual Residence of Decedent	40	Yrs,			DELOBE	1 10,1970	DC DC
any			10c. City, T	own or Location					10d. Inside City Limits
and show	or	Maryland St. Mary's	Me	chanicsv	ille				1 Yes 2 X No
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland (eath and henlar Hygienein (realth and Menlar Hygienein them 21 is marked other than "matural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	Director	10e. Street and Number 28993 Dandelion Drive		10	f. Zip Code 20659)		10g. Citizen of What Co. United Stat	
with t ns 23a be not		11. Marital Status 12. Was Decedent E	Ever in U.S	. 13. Was De	ecedent of Hisp	anic Origin? (§	Specify Yes or No	14. Race - Ame	rican Indian, Black,
death or iten	Funeral	Never Married 2 Married Armed Forces?	Z No		37	Mexican, Puert	o Rican, etc.)	White, etc.	Thite
s after ral",	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15, Decedent's Education (Specify only highest grade comp		1 Yes	s 2 No		work done	Specify: 16b. Kind of Business	
2 hour	ted	Elementary/Secondary (0-12) College (1-4 or 5-		during most of	of working life. I	DO NOT use re	tired)	Tob. Kind of Business	andusu y
5-0036 led within 72 h Hygiene. other than "n	Completed	12		Techni				Security	Systems
21215-0036 ould be filed within 7 i Mental Hygiene. r marked other than ic event, the Medica		17. Father's Name (First, Middle, Last)						Maiden Surname)	
121 Id be f fental narkes event,	Be c	Dee Morrison 19a. Informant's Name/Relationship (Type, Print)		19h Mailing Ad		Patrici		mber, City or Town, Stat	e Zin Code)
Baltimore, MD 2 pemit. Pages I and 2 shoul Department of Health and IV Important: If item 27 is m injury or other traumatic.	욘	Tricia Morrison/Wife			•			icsville, N	
e, N I and I Health Item		20a. Method of Disposition		ace of Disposition ematory or other p	(Name of cem	nton	ne 15,	20c. Location - City o	
MOF Pages ent of nut: If		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	10	nsfield-	-		2011	Charlotte	Hall, MD
Baltimore, permit. Pages lar Department of Hee Important: If ite		2. Signature of Funeral Service Licensee						-Echols F.H	
	(23a. Part I. Enter the disease, or complications that caused the	00817						Approximate Interval
Physician Medical		failure. List only one cause on each line.	ne deam, t	Do not enter the m	lode or dying, s	such as cardiac	or respiratory are	rest, shock, of fleart	Between Onset and Death
≟xaminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consection)	quence of):						
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ox 687 sath certific attending properties or use as the	cian	past 12 months?	ime of dea	2 Fetald	eath 3 ((Specify)	Ectopic pregr	ancy	Month	Day Year
Box e death c the atten ed for us	hysi	1 Yes 2 No 9 Unknown 9 Unknown		- Citici					
Division of Vital Records, P.O. Box 68760, Hospital or Attnating Physician: The law requires that the death certificate be Parantal after death. Funeral Director: After this certificate has been signed by the attending physicial price of the funeral director, page 2 should be detached for use as the bur	by P	Part II. Other significant conditions contributing to death	but not res	sulting in the unde	rlying cause giv	ven in Part 1.		obacco use contribute to s 2 ✔ No 3 Pro	_
of Vital Records, P.O og Physician: The law requires that that the this certificate has been signed be neral director, page 2 should be detax	jted		<u>-</u> -				24a. Was	an 24b. Were a	utopsy findings available
COT law r e has b e 2 sh	Completed						autor	ormed? death?	completion of cause of
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Vita	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatien	nt 2 🗸 E	ER/Outpatient 3	DOA C	Other Nurs	ing Home 5	Residence 6 Othe	er:
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Sior Vttend death ctor:	catic	2 Accident Investigation				es 2 No	guard rail	Street and Number or R	ural Pauta Number City
Division pital or Attenditions after death, teral Director:	Certification:	3 Suicide 6 Could not be determined (Specify) Intel	•	ne, farm, street, fa xpress	ictory, office bu	illaing, etc.	or Town, S		
		29a. Certifier 1 Certifying Physician: To the best of my	knowledge	e, death occurred					
To the To the To the Complet	Medical	one) 2 Medical Examiner On the basis of exam and manner stated. 29b. Signature and title of certifier	ination and	uror investigation,	in my opinion,		at the time, date	and place, and due to t	
(BA)	~	Zap. Signature and mile of certifier			O.C.M			June 11, 2011	sinii, Day, i Gaij
OCME (10)		30. Name and address of person who completed cause of de			- · · ·			1000	
('/	até	Mary G. Ripole MD. Deputy Chief Medic 31. Date filed (Month, Day, Year) 32. Registrar		•		Street, Balt	more, MD 2	1223	
Regis	trar	31. Date filed (Month, Day Year) 6 201 32. Reg strar	un	A. Son	Kel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 5:28 PM MASON 20 l Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Maryland Baltimore Itimore City Greneral 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Poreign 7. Age (In yrs. last birthday) **Funeral** Hours Min. Yrs Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits shov 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 Yes 2 No 10g. Citizen of What Country? 10. Zip Code 10e. Street and Number ō 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Funeral 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1. Marital Status Black, White, etc. 1 Yes 2 No þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No BIAC Specify Specify: 3, Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Sugar Be 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland Father's Name (First, Middle, Last) ည MASON 19a. Informant's Name/Relationship (Type, Print) Dirugh Fer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Acque 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 KBurial 2 Cremation 3 Removal from State MRKSIRY WhARTEN 4 ☐ Donation 5 ☐ Other (Specify) with Mater 22. Name and Address of Facility W: I Ams nature of Funeral Service Licensee ACCOMAC Va 23301 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Examiner acrtic Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit e Hospital or Attending Physician: The law requires that the death certificate be executed 1.24 hours after death. e Funeral Director: After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live Birth 2 Fetal death 3 Ectopic pregnancy Day Month Year 5 Other (specify) Pregnant at time of death Yes 2 No ed by the a detached f 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. within 24 hours after death.

To the Funeral Director: After this certificate has been signed to completed filled in by the funeral director, page 2 should be detended. ģ 2 No 3 ☐ Probably 4 ☐ Unknown tension Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 26. Place of Death (Check only one) Be 25. Was case referred to medica examiner? Other: 1 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: work?
1 Yes 2 No injury Natural 5 Pending Investigation
6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29d. Date signed (Month, Day, Year) 29b. Signature and title or certifier ပ 5/1/ MD 000 63086 who completed cause of death (Item 23a) (Type, Print)
R99 827 Linden Lienue Baltimore MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ JUNE 2011 WARREN BAXTER MCGINNIS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** OUEEN ANNE'S CHESTERTOWN 108 EAST STREET If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** Hours 1 X M 2 🗆 F 216-40-4814 10-4-1941 Director 69 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a State 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 X No MD **OUEEN ANNE'S** CHESTERTOWN 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 EAST STREET 21620 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married چ ک Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Yes, Give Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DRIVER CHEMICAL TRANSPORTATION Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ PAUL BAXTER MCGINNIS MARY ESABELLE JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a tant: If item 27 i 108 EAST STREET CHESTERTOWN, MD 21620 NANCY MCGINNIS/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot X Burial 2 ☐ Cremation 3 ☐ Removal from State CHESTERTOWN, MARYLAND CALVARY CHAPEL CEMETERY6/18/2011 4 ☐ Donation 5 ☐ Other (Specify) FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. Silanat, re of Funeral Service Lice 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Parl 1. Enter the disease, or complication, that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Oset and Death Immediate Cause (Final Phylician/ disease or condition resulting in death) Medical Due to (or as consequence of Examiner Sequentially list conditions. Examine Due to for an a consequence of cause. Enter Underlying Cause (Disease or iinjury the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Completed by Physician/Medical death certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Year Month ò in the past 12 months? Day Pregnant at time of death signed by the at I be detached fo 9 Unknown g 🗌 Unknown P.O. The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 🗌 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy page 2 performed? 1 Yes 2 No certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) or Attending Physician: Be examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral programmer. work? injury Natural 5 Pending 2 🗌 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title certifie D00517 S 2

DHMH 17 Rev 7/2009

State Registrar

ms

30. Name and addre

31. Date filed (Month, Day,

death (Item 23a) (Type, Print)

Signature

of person who completed cause of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Brenda Gertrude Mitchell 0540 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury Rehabilitation 4 Nursing Ctr. 5. Social Security Number 6. Sex 7. Age (in yrs. last biolinday) isburg Wicomico If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last bidhday, 8. Date of Birth 9. Birthplace (State or Foreign MD^{Country)} Days 1 □ M 2X□ F Months 63 82 63rrs. Hours Min 8-6-1947 Director 219-46-4387 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director Salisbury Wicomico 1 Tes 2 X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2003-B Huntsman Drive 21801 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. q 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2X No Specify: SpBikack "natural" Completed 3 Widowed W Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Aide 12 Shore-Up! Inc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ May E. Jones Kenneth M. White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10550permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau South 8th Ave, Apt F, Mt. Vernon, NY Kevin J. Hutt/Son timore, 20a. Method of Disposition ²⁹ n Blace of Disposition (Alame of ome) Cen. 5/13/P11 Show HIII Town State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Flower-Hill-Cem ===13=201-1 Eden,-MD 21. Signa Service Lice Bennie Address of Excility 917 W. Isabella St. Salisbury, Funeral Home 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown s been signed be should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ျ 1 🗌 Yes 2 410 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 4 Natural 5 Pending s after death. 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 6 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 State Registrar

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item#20b/c-wchd-te-5/12/11-amended

renda

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Physician/ Medical Month 05 7258 AM 201 <u> Alvin Lewis Million</u> 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Teomico Salisbur Hospice joastal 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year | If Under 7. Age (In yrs. last birthday) . Social Security Number Funeral Hours 01/21/1931 1 🔀 M 2 🗆 F Months Missouri Director 498-28-8384 Usual Residence of Decedent 10d, Inside City Limits or 28a-f show 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 🗌 Yes 2 🏋 No Ocean City Worcester Maryland | 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21842 12849 Townsend Lane 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 PA Yes 2 No. 1952-1953
If Yes, Give 1952-1953 Black White etc. 1 Never Married 2 Married þ Maryland 21215-0036 Specify: White 1 Yes 2 No Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Real Estate Broker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oma Weatherford Henry Clay Million 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6934 Ellingham Circle, Unit C, Alexandria, VA 22315 Amber Million granddaughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 05 | 13 | 2011 Alexandria, VA Ivy Hill Cemetery 4 Donation 5 Other (Specify) 22 Name and Address of Facility
Holloway Funeral Home P.A.
CFSF 501 Snow Hill Rd., Salisbu al Service Licensee ¥. Salisbury, Maryland 21804 Dominon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sould in a death.) Last Due to (or as a consequence of) Examine signed by the attending physician and be detached for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death Other (specify) Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Onknown To the Hospital or Attending Physician; The law requires within 24 hours after death.

To the Funeral Director; After this certificate has been sit completed filled in by the funeral director, page 2 should by 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \(\sum \) Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide ☐ Homicide determined Medical 1 Letrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) SHORE DR, SALISBURY MD 21804

DHMH 17 Rev 7/2009

State Registrar . Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		State of M	arylan			e of De		Mental Hy	'gien Reg. N		
	Physicia	ın/		(First, Middle, Last,							2. Date of De	eath	2 Year	3. Time of Death
-	Medic Examin		4a. Facility Name (if	not institution, give s	treet and number)	2.		4b. City	Town, or Lo	ocation of Deatl	03	4	c. County of Death	0615 M
and the same	ŗ			la Region				5	2/156	ury			Wicom	6211
	Funeral Director		5. Social Security No Unk Usual Residence of	1 [7. Ag	e (In yrs. la	st birthday) Yrs.	Months		If Under 24 Hrs. Hours Min			-20/1 9. Birth	pplace (State or Foreign ntry) Maryland
	rland f show dat	tor	10a. State	10b. County			, Town or Lo							10d. Inside City Limits
	r 28a- notifie	Director	MD 10e. Street and Nun	Wicomic	0	Sal	isbur		p Code			- 10 0		1 ☐ Yes 2 🗶 No
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Balt	permit, Page Department of Important: If any injury or once.		21. Signature of Jul	neral Service License	Took		B F	. Name a enni uner	e Sm	of Facility 91 ome Sa	7 W. I lisbur	sab Y,	ella St MD 2180	1
	Cote be executed by Medical Examiner bulksician and sthe burial-transit	edical Examiner	shock, or hear Immediate Cause (disease or condition resulting in death) Sequentially list confiant, leading to in- cause. Enter Under Cause (Disease or that initiated event- resulting in death) I	nditions, mediate tying injury	e cause on each line	a conseque	ence of): Ares Grice orj.						18ws	Approximate Interval Between Onset and Death
. Box 68760	or Attending Physician: The law requires that the death certificate after the death. Interder Atter this certificate has been signed by the attending phy in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 i 1 ☐ Yes 2 ☐ g ☐ Unknown	nonths?	3c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	Ideath 3	Ectopic Other (s	pregnancy pecify)				23d. Date of deli Month	very Day Year
ls, P.O.	v requires that to been signed by should be deta		Part II. Other signif	icant conditions co	ntributing to death b	out not resu	ulting in the u	nderlying	cause giver	n in Part I.				the cause of death?
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ital	sician: The certificate rector, pag	Be	25. Was case referrence examiner? 1 Yes 2	. –	ospital:					e of Death (Che				
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	To the Hospital of within 24 hours of To the Funeral of completed filled it	Medical	(Check 2 only one) 3	☐ Certifying Nurse	er: On the basis of e	xamination	and/or invest	igation, in	my opinion,	death occurred	at the time, date	and place	e, and due to the c	ause(s) and manner stated.
	1 wit		29b. Signature and	title of certifier	-6		2		c. License n		6	29d. D	ate signed (Month,	Day, Year)
			30. Name and address Bruce	ess of person who co	empleted cause of d	leath (Item	23a) (Type, P	rint)	و ر <u>و</u>	repoll	St. S	alic	bur N	11) 2180 /
	Stat Registra		31. Date filed (Mont		32. Registr	ar's Signat	ure A	bar	J.	0,,0.1		W "C	7	<u> </u>

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ralph McClure 2011 Merrill 4:36 p June Medical 4a. Facility Name (if not institution, give street and number) County of Deau Wicomico 4b. City, Town, or Location of Death Examiner Fruitland 402 Yorkshire Court Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 118-22-3351 1071871921 Michigan Director 89 Usual Residence of Decedent ms 23a or 28a-f shor must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Fruitland Maryland Wicomico 10e. Street and Number 10g. Citizen of What Country? Funeral 21826 402 Yorkshire Court ral", or items ? death 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examiran injury or other traumatic event, the Medical Examirans in the Medical Examiran Completed by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement Carpenter Master Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Mabel Standish 2 Edgar David McClure 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 Yorkshire Court, Fruitland MD 21826 Rose H. McClure/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 6/7/2011 Salisbury, MD Salisbury Crematory 4 ☐ Donation 5 ☐ Other (Specify) Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Dompson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hem c disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PY D Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this course. that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician a should be detached for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed' Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗹 No Hospita Other: 1 Tyes ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify, To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 29d. Date signed (Month, Day, Year) ne and address of person who completed cause of death (Item 23a) (Type, Print) Powe Alon Dans 00 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

1 - For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Eleanor McKenzie 4:20 PM 28 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SALIS BURY Social Security MANDER 6. Sex WICOMICO 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birtholace (State or Foreign **Funeral** Days Hours Min. ntry Months 577-01-54 1 ☐ M 2 📉 F Yrs. Director Usual Residence of Decedent with the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or items 23s or 28e-f ehow the Modical Exercitive trust by contributed 1 Yes 2 No ALISBURY Completed by Funeral Director MD MICOMICO 10g. Citizen of What Country? 10e. Street and Number ILIO HEALTHWAY DR 21801 SAکد filed within 72 hours after death Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2▼No Specify: WHITE Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked of Pages 1 and 2 should be REBECCA JOHN ROSS WOLFE ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heelth ar Important: If itsm 27 is any injury or other trau ance. KEVIN MCKENZIE (SON) 27835 ISLAND DR SALKBURY, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SAUSBURY, MID SALLS BURY Crematory 21. Signature of Funeral Service Licensee 22. Name and Address f Facility MESSICK FUNERAL HOME POBOX 61 BIVALUE MD 91814 Part 1. Lefer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** lespiratory /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine rsicien and e burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at I be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 1 Yes 2 No 1 Yes Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence 6 Ither (Specify) 455.5414 1; Was 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation s efter death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours e To the Funerel I filled To the Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. MD 29b. Signature and title of certifier Ahmed 29d. Date signed (Month, Day, Year) Zareen 29c. License number D0071277

State Registrar

106 mil ford 5+ 31. Date filed (Mog

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stc 504 Registrar's Signatur

Salisbury

MD 2180

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar amended item 24a-t.e.wchd-6 Pertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Arline Mascarich Month Medical May 4:06 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 917 Colony Drive Salisbury Wicomico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Hours 0870371936 74 New York 073-30-1514 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a State death with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Wicomico Salisbury 1 Tes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral items 23a 917 Colony Drive 21804 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 K Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", Specify white Completed 3 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) the Dental Hygenist Dental Care and Mental Hygie is marked other æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George L. Born permit. Page 1 and 2 should be 1 Department of Health and Menta Margaret Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra George Mascarich/spouse 917 Colony Dr., Salisbury, MD 21804 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 D Removal from State Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 6/02/2011 21. Signature of Fuseral Service License Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner REPAIR Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed (OLON COLOSTOMY ISCHEMIA SIP RESECTION that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical YPERTENSION Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Dav Vear g Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DYSLIPIOBNIA 1 ☐ Yes 2 ☐ No 3 📝 Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 📈 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Man xr of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 050929 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VOY MADARANG SALISBURY 1405 LEWIS 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0:19/A Annabelle Neilson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western Maryland Regional Medical Center Allegany <u>Cumberland</u> 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 1 □ M 2 **X** F Months Days Director 215-20-6713 90 September 02, 1920 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f shorexaminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18657 Cherry Lane S.W. Funeral 21532-U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔊 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2X No Specify: "natural", 3 ★ Widowed 4 □ Divorced Specify: Year or Dates White injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alexander Bell McAlpine Anna Marie Hausrath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 Andrea Taylor daughter 21532-18653 Cherry Lane Maryland Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Frostburg Memorial Park June 04, 2011 Frostburg Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 B 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ HEMORRHAGES, INTRACRANIAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and -transit requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Dav Pregnant at time of death Year 9 | Ilnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has performed 2 🗌 No 1 🗆 Yes 25. Was case referred to medical examiner?
Yes 2 \sum No Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending FELL FROM PORCH s after death. 1 Yes 2 No Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 265 T 10 m 8 Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. august 7.7 gueron D001438 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 KENT AVE CUMBERLAND MO 21502 AUGUSTO F. FIQUEROA JR State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rosemary Constance O'Reilly June 10, 2011 8:57 а м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Chevy Chase Manor Care-Chevy Chase 5. Social Security Number 9. Birthplace (State or Foreign Country) D.C. If Under 1 Year If Under 24 Hrs. **Funeral** 6 Sex 7. Age (In vrs. last birthday 8. Date of Birth Days 1 M 2 T Hours $J_{\mathbf{u}}^{Month, Day, Ye}$. Year) 925 85 214-60-5343 **Director** Usual Residence of Decedent 28a-f shov 10b. County Montgomery 10c. City, Town or Location Kensington 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No or 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 20895 USA 4301 Knowles Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 0 1 Never Married 2 Married Completed by 1 Yes If Yes, Give SpecifyWhite 1 Yes 2 No Specify: "natural", 3 Midowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Secretary National Gallery of Art Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Maloney Elizabeth Ann Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10347 Metropolitan Avenue, Kensington, MD 20895 .0 Thomas O'Reilly/Son 1 and 2 s if Health item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Date Important: If it any injury or o Gate of Heaven Cemetery June 1 2011 Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee frencis Adgess Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical vanced Dementia Due to (or as a c Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Q Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? this certificate Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 2 \(\text{A} \) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred nin 24 hours after death.

the Funeral Director: After in pleted filled in by the funera 5 Pending 1 Tyes Accident Suicide Investigation 6 Could not be 2 🗌 No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State

31. Date filed (Mont Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State	Type or Pri State of M		d / Depa	artme		lealth and		ygien	e	e. 20	300
	Physicia	an/	1. Decedent's Name (First, Middle, Last, CHARLES OU	VEUS		Cer	unca	te or L	<u> </u>	2. Date of D		ay Yea	r .	me of Death
	Medio Examir		4a. Facility Name (if not institution, give s	treet and number)	111	1	4b. Cit	y, Town, or	Location of Dea	MAY th	4	c. County of De	eath •	126 M
-40	Funeral		5. Social Security Number 6. Seg	MACAL 7. Ag	je (In yrs. la	ast birthday)	If Unc	er 1 Year	// 56/// If Under 2/ Hr	S. 8. Date of B	irth		MICO Birthplace (St	tate or Foreign
	Director		221 02 0170	7. Ag	61	Yrs.	Months	Days	Hours Mir	10 30	1949	F	orida	
	and show dat	to	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation		-				10d. Insid	de City Limits
	e Mary r 28a-f notifie	Director	Maryland Wicomico 10e. Street and Number		D∈	elmar	1404 -							Yes 2 X No
	with th	Funeral I	29540 Connelly Mil	ll Rd.				ip Code 375			US	Citizen of What	Country?	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give		li li	Vas Dec f Yes, sp	edent of His	n, Mexican, Pue	Specify Yes or No to Rican, etc.))-	14. Race - Ar Black, Wh	nite, etc.	ın,
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Maryland	should h and h 7 is ma rauma		19a. Informant's Name/Relationship (Typ	e, Print)		1	-	ss (Street a	and Number or F	ural Route Numb	-			-
re,	f Health item 2		Karen Owens wife 20a. Method of Disposition			lace of Dispo	sition (N	ame of	1	Date Date		laryLand Location - City		-
Baltimore,	Page ment o ant: If ury or		1 ☐ Burial 2 🔀 Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)			emetery, cren isbury				13 2011	1	lisbury		
Balt	permit. Depart Import any inj once.		21. Signature of Pineral Service License	Klan.	. 1			and Addres	uneral I	Home P.A Salisb		Marria	nd 21	904
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on	ications that caused	d the death							maryra	Approx	
	hysician	8 1	Immediate Cause (Final disease or condition resulting in death)	Netast	he	Ad	NOC	AICIN	ONA				Oy et	and Death
24	Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):								
	_ =	iner	Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ence of):								
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Box 68760	or Attending Physician: The law requires that the death certificate be after death. After death. Tierctor, After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the bu	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	Ideath 3	Ectopio Other (pregnancy	У			23d. Date of o	delivery Day	Year
P.O.	that the des	y Ph	Part II. Other significant conditions cor	tributing to death b	out not resu	ulting in the u	nderlying	cause give	en in Part I.	23e. Did	tobacco	use contribute	to the cause	of death?
ds,	requires to been signal should be	ted b	AttIAL FIBRILLAND	/						1 🗆	Yes 2	2 No 3 No	Probably 4	1 Unknown
SCOL	r; The law re icate has be r, page 2 sh	mple	COPD,							24a. Was	s an opsy formed?	24b. Were a prior t death	autopsy findi o completion	ings available of cause of
al Re	sician; The certificate I rector, page	Be Co	25. Was case referred to medical					26. Pla	ce of Death (Ch	1 🗆 Yes			es 2 🗌 No	>
Vita	Physician; this certific al director,	To B	TEL TES ZEINO	ospital:		ER/Outpatien	t 3 🗆 I	Otho	r'	Home 5 ☐ Res	sidence	6 ☐ Other (Sp	ecify)	
n of	ding Ph h. After th funeral	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of inju (Month, Da		28b. Time of injury	М	28c. Injury work?	at ? Yes 2 🗆 No	28d. Describe	how inju	ry occurred		
Division of Vital Records,	To the Hospital or Attending I within 24 hours after death. To the Funeral Director, After completed filled in by the funer	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At hor c. (Specify)	me, farm, stre			163 2 🗀 140	28f. Location City or To		nd Number or F e)	Rural Route N	lumber,
_	Hospital 24 hours a Funeral I	Medical	29a. Certifier 1 Certifying Physic (Check 2 Medical Examin	er: On the basis of e	xamination	and/or invest	igation, ii	n my opinio	n, death occurred	l at the time, date	and plac	e, and due to th	e cause(s) an	d manner stated
	To the within 2 To the comple	Ĕ	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	Practioner: To the	best of my	knowledge, d	leath occ	urred at the	time, date and p	lace, and due to t	he cause	(s) and manner ate signed (Mor	as stated.	
0	Willia .		Mellen M.	Balda	(de)			D148	140		5	117/1	/	
,	"De All		30. Name and address of person who co	54	eath (Item	23a) (Type, P		Br.	5A	USKIY .	MS	2/801		
	Stat Registra		31. Date filed (Month, Day, Year) NAY 18 20	32. fegistra	ar's Signati	B. A.	ark			/	ľ			

State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Month Physician/ Beverly June 5:25 p.π. Anne Pryor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 21981 Spring Valley Drive exington Park Year If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours Min (Month, Day, Year) 2/09/1935 Yrs Director 214-32-9602 Washington, DC Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f 1 Yes 2 X No Maryland St. Mary's Lexington Park 10e, Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 21981 Spring Valley Drive 20653 United States permit. Page 1 and 2 should be filed within 72 hours after death \(\) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bowling 8 Clerk Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ James Elmer Hooper Elva Mollie Garrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21981 Spring Valley Drive, Lexington Park, MD 20653 Paul A. Pryor 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Brinsfield-Echols Cre06/16/2011 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Tuneral Service Licenses
Edward N. Brinsfield, M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final non-small cell was lancer Physician/ metastatic disease or condition resulting in death) rears Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Que to for as a monsequence off cause. Enter Underlying Cause (Disease or iinjury Examir attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death n signed by the ar 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown should ! Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy After this certificate has page 2 Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) Hospital: 2 1 No ဂ္ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 12 Natural injury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completed filled in by the fu ☐ Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50686 11 6 BA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gurdeep S. Chhabra, M.D. 23415 Three Notch Road, California, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Ye

32. Registrar's

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5 2011 A M The lma Adkins Parsons 9:14 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1514 Riverside Drive, Wicomico Apt. C314 Salisbury Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours Min (Month, Day,) 85 Maryland Director 213-22-6075 Usual Residence of Decedent or 28a-f show notified at e i and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f shown other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector 1 Yes 2 X No MD Salisbury Wicomico ā 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 514 Riverside Drive, Apt. C314 21801 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 . Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: White Specify Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Vernon Powell Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Shores Adkins Rose Marion С. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 94102828 Franklin Street, Apt. 805, San Francisco, CA Michael Parsons - son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 permit. Page 1
Department of I
Important: If it
any injury or or 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 5-9-2011 Delmar, Delaware Crematory of Delmarva . Signature of Funeral Service Lice 22. Name and Address of Facility Bounds Funeral Home E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or conhock, or heart failure. List on lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events resulting in death) Last use as the burial-transit signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No 5 Other (specify) Month Day Year Yes 2 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 a autopsy performed Yes 2 death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🄀 Natural 2 🔲 Accident work?
1 Yes 2 No 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 642 10000 CFNP 2011 01 06 completed cause of death (Item 23a) (Type, Print) 30. Name and addres person who

Registrar
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31. Date filed (Month

Day, Year)

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CFNP

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11219a Per INF C917 7/18/2011 JH State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09 2011 Year Month 06 1:03pmM Sylvia Maud Pierce 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince George Hyattsville If Under 1 Year | If Under 24 Hrs 700 Rittenhouse Street Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Social Security Number Months Davs Hours Min. 1 ☐ M 2 🔀 F Yrs. 12/12/ Washington, DC 78 577-46-7174 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Md Hyattsville Prince George 1 TXYes 2 TNo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 700 Rittenhouse Street 20783 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black If Yes Give Specify: XXWidowed 41 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Land Law Examiner 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Etta Redmond Edgar Telefaro Redmond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Belationship (Type. Print) 700 Rittenhouse St Hyattsville, Maryland Michelle G. Redmond Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 06/16/2011 Riverdale, Maryland 1 ☐ Burial 2 ☐ Seremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Crematory 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Snead Funeral Home & Cremation 5732 Georgia Ave NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Bladder Cancer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2X No 3 🗆 Ectopic pregnancy Day 5 ☐ Other (specify) Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 📉 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical **Examiner** Box 68760 P.O. Records, Division of Vital

requires that the death certificate be executed sician and burial-trans attending physician ρį ned by the a has Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral director, the filled in by 24 hours a completely

Physician

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Funeral

Director

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within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Certification: To

Medical

State

29a. Certifier

(Check only one)

/Medical

Registrar

29b. Signature and title of certifier

29c. License number D23743

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 06/10/2011

30. Name and address of person who completed cause of death (Item 23) (Type, Print)

7525 Greenbelt Dr Greenbelt, Md 20770 Martin Weltz M.D.

31. Date filed (Month, Day, JUN 1 3 2011

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (= State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0209 Beatrice Oueen May 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Anne Arundel Medical Annapolis Center Social Security Numbe If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** 8. Date of Birth Days Hours Min. June 26 S. Carolina 1 M 27 1926 Director 216-20-9599 84 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho her must be notified at Director 1 ☐ Yes 2 X No Marvland Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 995 Waterbury Heights Dr. 21037 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner à 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 ♥ Widowed 4 □ Divorced Black Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) University of Md. Elementary/Seconday (0-12) College (1-4 or 5+) 12th 0 Dietician Medical Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David Sutton Plumbi Knox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaVern Contee(Daughter) Gohagen Rd. Upper Marlboro, Md. 16906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) 6-3-11 Cedar Hill Brooklyn Park, Md. Signature of Funeral Service Licenses Amane a Recense f Facility Sons Mortuary, P.A. Jan 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the diselese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequent e of) Examiner Sequentially list conditions Examiner Dire to for as a nonsequence off cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month Day ☐ Pregnant at time of death ☐ Unknown the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed Yes 2 After this certificate 1 Yes 2 No 25. Was case referred to medica æ 26. Place of Death (Check only one) Hospital 2 T-M မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert W. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) istrar's Signature State JUN 0 8 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Bernarda LoPresti Quattrocchi 2011 0130 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Calvert Manor Healthcare Center Rising Sun Ceci1 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days (Month, Day,) March 21 1 □ M 2 🛚 Hours Min Director 215-30-0337 85 Italy Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Maryland Ceci1 Port Deposit 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21904 62 Doctor Jack Road Cecil 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes. Give 1 ☐ Yes 2 🔀 No Specify. 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Joseph A. Banks life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ Homestead, Maryland Tailor Six Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Carmelo LoPresti Salvatora Caterina Fazio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Faxio 62 Doctor Jack Road, Port Deposit, Maryland 21904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place)
HOTLY HILL 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 06/13/11 Middle River, Maryland Memorial Gardens Signature of Funeral Service Licenses Lee A. Patterson & Son Funeral Home, power Perryville, Maryland <u> 21903-0766</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ old necta Cardnoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a nonsequence of and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 4 Pregnant Month Dav Year Pregnant at time of death Yes 2 X No the g Unknown ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 🗓 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury work?
1 Yes 2 No ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director:,
completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 2011 rerdin 00044373 and address of person who completed cause of death (Item 23a) (Type, Print) Joseph K. Weidner, Jr., M.D., 101 Colonial Way, Rising Sun, Maryland 31. Date filed *(Month, Day, Year)* **JUN 1 3 2011** \$2. Registrar's Signature State Registrar

11-04131 Calvin Ragan

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			Western Regional Me	dical Center			Cumberland			Allegany	
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<u></u>	cian: The certificate ector, page	BB (25. Was case referred to medical examiner?	1.1				of Death (Chec	ck only one)		
Division of Vital Records,	hysic this	٥	1 ✓ Yes 2 No	Hospital: 1 1	npatient 2 🗹	ER/Outpatier	it 3 DOA	ther 4 Nur	sing Home 5	Residence 6	Other:
ð	ling Ph After (funeral	딭	27. Manner of Death	28a. Date (Month	of Injury , Day,Year)	28b. Time of			28d. Describe	how injury occurred	d
5	Attendi death. cctor: yy the f	읥	1 V Natural 5 Pend 2 Accident Inves	ing tigation			1 Ye	s 2 No			
S	r At ter d	Ë			e of Injury - At h	ome, farm, stre	eet, factory, office bui	ilding, etc.			or Rural Route Number, City
ä	Hospital or Atten 24 hours after death Fuoeral Director: tely filled in by the	Certification:		mined (Specify)					or Town, S	state)	
	e Hospital 24 hours e Fuoeral etely filled	_	29a. Certifier 1 Certifying Pt	ysician: To the bes	at of my knowled	ge, death occu	urred at the time, date	and place, a	and due to the caus	se(s) and manner a	as stated.
	# H # e	Medical				nd/or investiga	ation, in my opinion, o	death occurre	d at the time, date	and place, and du	e to the cause(s)
		₩ W	29b. Signature and title of certifie	and manner s	ialeu.		29c. License	number		29d, Date signed	(Month, Day, Year)
	sels	1 / X (/ / /)						O.C.M.E. June 3, 2011			
	1	1	The state of the s	end)							
1	العا		 Name and address of person Laron Locke MD. A: 	•			altimore Street,	Raltimore	MD 21223		
700,000					egistrar's Signatu			Daiminole	, IVID 2 1223		
	St Regist	ate	31. Date filed (Month, 1) K+a(6 2011 32. Re	enstrars Signati	A. A	arke				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June Michael Joseph Rehbein, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Regional Laurel Hospita Laure 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 8, 1958 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 □ F Hours Director 212-80-9039 May 53 Usual Residence of Decedent or 28a-f show notified at 10a, State 10c. City, Town or Location death with the Maryland Director MD Howard Jessup 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be Funeral 7775 Sharewood Drive 20794 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status þ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 - Widowed 4 - Divorced Completed M-dical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Francis Rehbein Elizabeth Schneider Peggy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Joseph Rehbein, Jr./son 6107 Hunt Club Road Elkridge, Maryland 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ardent Crematory 6/13/2011 Hanover, Maryland 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service License - M00957 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Myocardial Physician/ Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): the burial-transit The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death been signed by the s should be detached t P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitus Diabetes Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an page 2 s autopsy performed? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 X No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work?
1 Yes 2 No 5 Pending 24 hours after death. Funeral Director: A М ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) 022966 30. Name and address of person who completed cause Adeath (Item 23a) (Type, Print) Laurel Regional Hospital, Emergency 12 7300 Van Dusen Rd. Thomas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Interval Between Onset and Death

1 🗌 Yes 2 🛶 No

County of Death

Prince George

14. Race - American Indian

White

Black, White, etc.

Automobile

23d. Date of delivery

death?

10

1 Yes

Day

24b. Were autopsy findings available prior to completion of cause of

2 No

Year

Month

Specify:

Mary Land

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death J Month Physician/ 1229 PM oun 011 Medical 4c. County of Death Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner of Maryland nivus-tu Bratt Male 7. Age (In vrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Months Days Hours Min. 08 106 11975 Maryland 215-82-6527 35 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🕇 No MD Harkord Edaewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1467 R. Court Harford Square U.S.A. 21040 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Research Pharmaceutical n and Mental Hygien is marked other t permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Michael J. Roach, Sr. Cecilia R. Wyatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Cecilia R.</u> Blevins (Mother) 138 Remington Circle, Havre de Grace, Maryland 21078 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R.A. Ferris & Co. Inc. 06/15/2011 | West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lellman Funeral Home, F.A. all re of Funeral Service Licensee 123 S. Washington St., Havre de Grace, MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Set only one cause on each line. shock, or heart failure. Immediate Cause (Final Onset and Death Ph, sician/ KIN disease or condition Medical resulting in death) Due to (or a consequence of) **Examiner** countries flet in in 1th ins if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami attending physician and for use as the burial-transit that the death certificate be executed POKIA Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the sid be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown Completed should peen: 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 24 hours after death.

9 Funeral Director: After this certificate has leted filled in by the funeral director, page 2 s autopsy performe 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\text{\text{\text{Nursing Home}}} \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) ပ 2 No ER/Outpatient 3 DOA 1 Mnpatient 2 🗌 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2. 3 only one and title of certifier 29b. Signatu 29d. Date signed (Month, Day, Year, 487828885 person who completed cause of death (Item 23a) (Type, Print) Name and address of Baltmar

State

Registrar

Greene

Jouth

Grasone.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June 6, Catherine C. Reynolds 2011 4:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atria Assisted Living Salisbury Wicomico 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Days Hours Director 214-12-8503 05/05/1920 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 1 X Yes 2 No Maryland Worcester Ocean Pines 5 10e. Street and Number 10g. Citizen of What Country? Examiner must be 23a Funeral 412 Ocean Parkway 21811 USA items 2 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Midowed 4 Divorced white Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) within 72 than Elementary/Seconday (0-12) College (1-4 or 5+) filed within al Hygiene. the Homemaker Domestic other Be Department of Health and Mental Himportant: If item 27 is marked other any injury or other **** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anthony Rakowsky Catherine Dresky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Carrick/son 76 Boston Dr., Ocean Pines, MD 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place). Arlington National Cemetery 4 Donation 5 Other (Specify) 8/24/2011 Arlington, VA 21. Signature of Funeral Service/License Polloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit ause (Disease or linjur) and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed Yes 2 No 1 Yes 2 🗌 No To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) H55isted Hospital: 2 🗹 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 🛮 Natural injury 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0071277 7.11 SIE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 MILFORD ST, STE SOUB, SALISBURY MD AHMED MD 31. Date filed (Me Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 Jun 19. 6:48 PM Ritchie Elaine Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Egle Nursing Home Lonaconing Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Gountry) MD Min. (Month, Day, Aug 8, Hours Director 213-22-3128 91 Usual Residence of Decedent 28a-f show 10b. County 10a. State within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Lonaconing 1 XYes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 57 Jackson Street 21539 USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 □xWidowed 4 □ Divorced Completed white Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natui jury or other traumatic event, the Medical jury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food service **Board of Education** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nellie Brain John William Ritchie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Bruce Ritchie 30Ž10 Southampton Bridge Rd. MD 21804 nephew Salisbury permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 6/23/201 Frostburg Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) MD Frostburg 21. St nature of Juneral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, CONGESTIVE disease or condition Medical resulting in death) Examiner CORONARY if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director Attack. use as the burial-transi signed by the attending physician and dbe detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) ____ Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📮 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes Certificate: To 2 40 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 🗌 Yes 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical *Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier 29d, Date signed (Month, Day, Year) 126907 JUNE 20 0 dy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 25 BISHOP NALSH RD. CUMBERLAND, MD 21502 HARITT SIDHU MO 31. Date filed (Month, Day, Year) JUN 2 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death William Charles Reecher ^D2011 June Physician/ 20 1:28 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 22842 Cavetown Church Rd. Smithsburg Washington If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 🕎 M 2 🗆 F Hours Min Maryland **Director** 14-34-0239 75 June Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant I fitem 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Smithsburg Md. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 21783 22842 Cavetown Church Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) A&P Tea Co. District Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elenora McKenrick George Edwin Reecher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22842 Cavetown Church Rd. Smithsburg, Md. 21783 Patricia A. Reecher (Wife) permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 22, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory Smithsburg, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. M01414 J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) 0 Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year as been signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? After this certificate 2 No To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No ၉ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, pleted filled in by determined Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29c. License number D0054 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

JUN 2 4 2011 32. Registrar's Arrey State

DHMH 17 Rev 7/2009

Registrar

Box 68760

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Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month June 2011 9:30 a.M Thelma Marie Schrader 16, Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Hospice House of St. Mary's St. Mary's Callaway 5. Social Security Number If Under 1 Year | If Under 24 Hrs. g. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Hours Min 10/03/1934 Director Washington, DC 579-48-8519 76 Usual Residence of Decedent 28a-f shov 10a. State 10b. County the Maryland event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 T No Maryland St. Mary's Compton 23a or 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b. 22416 St. Clements Avenue 20627 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Τ. Robertson Henry Sarah Ε. Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Billy J. Schrader/Spouse Box 31, Compton, Maryland 20627 P.O. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Grd.: 06/22/2011 Leonardtown, MD Signature of Funeral Service Licenses 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition ere bro Medical resulting in death) Due to (or as a consequence of). Examiner Perten Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Atrial attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ⊢ ya: ∐ Yes 5 Other (specify) Month Day Year Pregnant at time of death signed by the ad be detached if Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 W Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 2 2 🗆 No 1 Yes 25. Was case referred to medical Hospice Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) House ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA this n 24 hours after ueau... ne Funeral Director: After th mated filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 V Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 689 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Vijaya Guduri, M.D.

32. Re

istrar's Signature

31. Date filed (Month, Day, Year)

24035 Three Notch Road Hollywood, Md 20636

11-04346	
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annes	Joseph	Schmidt,	JI.

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Physici		Decedent's Name (First, Middle	e,Last)							2	. Date of De		V		3. Time of Death
Medical Exami	iner	JAMES JOSEPH SO	CHMTDT. J	TR _							Month June 9, 2	Day 2011	Yea		1736 hrs
		4a. Facility Name (if not institution	n, give street and n	umber)		4	b. City, Tov	n, or Lo	ocation o	of Death		4	c. County o	f Death	
		Buckingham Landing					Cheste	town					Kent		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birth	nday)	If Under	Year	If Unde	r 24Hrs.	8. Date of E	irth (MN	I/DD/YYYY	9. Birt	hplace (State or
Director						,	Months	Days	Hours	_		1	964	Foreig	1
		214-94-4709	1 M 2 F	47		Yrs.					02/15	5/2 0	++	MA	KYLAND
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w any		Toa. State		Too. City	y, rown c	or Locatio	ΣΠ								10d, Inside City Limits
laryland 28a-f show at once,	9	MD QUEEN	ANNE'S	MIL	LING	TON									1 Yes 2 X No
Aaryl 28a-1	Director	10e. Street and Number					10f. Zip Co	ode				10g. Ci	tizen of Wh	at Coun	try?
the h	۵	217 LEGION ROAL	D				2165	1			- 1	IIN	ITED	СТАТ	res
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	Ē	11. Marital Status		cedent Ever in l	J.S.	13. Was			anic Orig	in? (Spec	cify Yes or N				can Indian, Black,
eath	Funeral	1 Never Married 2 X Ma	arried Armed F	orces?		If Ye	s, specify (Cuban, M	Mexican,	Puerto Ri	ican, etc.)		White	etc.	
", or		3 Widowed 4 Dive	1 Yes orced If Yes, Give Ya			1 \	Yes 2 🗓	No	specify:				Specify:	WHT	PF .
ırs afte tural",	d by	15. Decedent's Education (Spec	or Dates: cify only highest gra	ade completed)	16a. D		s Usual Oc			kind of wo	rk done	16b.	Kind of Bus		
5-0036 ed within 72 hou tygiene. other than "nat	Completed	Elementary/Secondary (0-12)		1-4 or 5+)	ه ا	luring mo:	st of workin	g life. D	TON OC	use retired	d)				•
36 hin 72 than chical	ᅙ	12			TR	IICK	DRIVE	TD.				Т	RANSP	ОВТИ	TTON "
d wit	ĕ	17. Father's Name (First, Middle,	Last)		110	NOOK	DKIVL		3.Mother	s Name (F	irst, Middle				TITON
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	To B	JAMES JOSEPH SO 19a. Informant's Name/Relationsh		K.	19b	Mailing	Address /				KENEN ral Route Nu	mbor (Tity or Tour	State	Zin Codo\
MD d 2 shot lth and 1 so 27 is numatic					LÝ.									i, Glale,	Zip Code)
and 2		SHEILA SCHMIDT 20a. Method of Disposition	- WIFE	1 20b	Place of	/ LL Dispositi	ion (Name	KUA of ceme	D MI		GTON,			City or	Town, State
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygient and the Health and Mental Hygient and the History 23 or 23s-fabe usit. If them 27 is marked other than "natural", or items 23a or 23s-fabe in other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 X Cremation	3 Removal f			ry or othe		OI COING	oldi y,		Jale	200.	Location	City of	TOWII, State
Page nent		4 Donation 5 Other Sp			ESAP	EAKE	CREM	ATI	on	06/13	3/2011	ST	EVENS	VILI	LE, MARYLANI
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi permer. Health and Mental Hygiene. Important: If item 27 is marked other tu injury or other traumatic event, the Med		21/Signature of Funeral Service		7		22. Na	me and Ad	dress o	f Facility	DETAI	c 31177	77.434	TWOTE	D 4 T	HOME, P.A.
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/Medical		failure. List only one cause	on each line. a. Drowning	0											Between Onset and Death
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this dir	리	1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Out	tpatient	3 DOA	· lot	ther ₄	Nursing t	Home 5	Resid	ence 6 🗸	Other:	Scene
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To the Ho within 24 P To the Pur completely	Medical	(Check only	niner:On the basis	of examination	and/or in	vestigatio	on, in my op	inion, d	death occ	curred at t	he time, date	and pl	ace, and du	e to the	cause(s)
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10		Clarita A	Jann.	, , , , , ,				C.M.							in, Day, real)
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	ſ	30. Name and address of person v													
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **U**tonth Kenneth W. Stanyard 2159 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** astimore 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 € M 2 □ F Hours 0 9407th Day 9884 Maserrand 216-74-1516 46 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Harford Havre de Grace 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 21078 United States of America 314 North Stokes Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 Yes : Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Auto Detailer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosalie Rutherford Ivan L. Stanyard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Susquehanna Ct., Havre de Grace, Maryland 21078 Ronald Stanyard (brother) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
ROCK RUN CEMETERY 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 06/17/2011 Havre de Grace, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington St, Havre de Grace, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No 1 Yes 2 9 Unknown 9 Unknown has been signed by e 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ 1 Inpatient 2 _ ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

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completed filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) Mynam House Staff 30. Name and address of person who completed cause of death (Item 23a) (Type 32. Registrar's Signature State Registrar

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Depart For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month , 20 PM Herbert Seward DI Medical Facility Name (if not institution, give street and number) County of Death Examiner 4b. City Town, or Location of Death 1Comico At If Under 1 Year 9. Birthplace (State or Foreign If Under 24-8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 1 💢 M 2 🗆 F Days Hours Min Director Yrs. 212-40-9314 68 8-13-194 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Wicomico Pittsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8001 Gumboro Road 21850 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married 1960-1 ☐ Yes 2 X No Specify: White Specify: 3
Widowed 4 Divorced 1961 Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Elihu Herbert Seward Katherine Hearne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Seward - Wife 8001 Gumboro Road, Pittsville, Maryland 21850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 5-9-2011 Crematory of Delmarva Delmar, Delaware 22. Name and Address of Facility Bounds Funeral Home Funeral Service License Salisbury, Maryland 21804 E. Main Street, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician, CHRONIC OBSTRUCTIVE PHLMOWARY DISRASR disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence or): cause. Enter Underlying use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 4 Nursing Home 5 Residence Hospital 1 Tes ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Natural 28b. Time of Certificate: 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature 29c. License number 29d. Date signed (Month. Day, Year) D0052410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ettur 21802 31. Date filed (Month, Day, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amended item#20b-wchd-te-6/15/11 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Cinderella Smith 06 2011 025 8AM Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death alisbun Hospice the Lak Jicomico Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth g. Birthplace (State or Foreign 1 □ M 2 🏝 F Days Hours Dec. 22, 1919 192-12-5806 Maryland **Director** 91 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Worcester Berlin 1 Yes 2 XNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21811 USA 112 Railroad Avenue items 2 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or ite 14. Race - American Indian. Black, White, etc. þ 1X Never Married 2 Married Maryland 21215-0036 Yes 2 No If Yes, Give Year or Dates Specify: Black 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Berlin Middle School Food Service 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Keith Showell Mintie Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Mosley/ Sister-in-law 226 Branch Street - Berlin, Maryland 21811 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Paul UMC Cemetery 55217/2011 Berlin, Maryland rvice Licensee 22. Name and Address of Facility Salisbury, Maryland any Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the de Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition CARCINDUM Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence oi). the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

Yes 2 □ No

Unknown Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 2 No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 24 No Other: ၉ 1 🗌 Yes 4 Nursing Home 5 Residence Pother (Specify) HOSPIGE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work within 24 hours area comes to the Funeral Director. Af 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20058400 06 106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 73 SACYBURY 21802 31. Date filed (Month, Day, 32. Reg rar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death L. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frances J. Satchell 0020 201 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TENISSULA edi CAL NIOMICO Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 3 – 26 – 1937 9. Birthplace (State or Foreign Country) DE **Funeral** 1 🗆 M 2 🔀 F Days Hours 74 **Director** 222-20-0079 Usual Residence of Decedent or 28a-f show 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 824 East Road 21801 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Yes 2 XNo 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: sparack "natural" Completed 3 X Widowed 4 Divorced Year or Dates or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) if Health and Mental Hygiene. Harrison Senior Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cook Living Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Ira Batson Mattie E. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra William Satchell, III 5993 Hunt 30093-2075 Run, Norcross, GA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Middleford Cem 6-11-2011 | Seaford, DE Bennie Smith ▲ Frineral Service License Agnature_ Isabella St. Salisbury, MD 21801 <u>Funeral</u> Home 23a. Part 1. Eleter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Du t Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Ta and the burial-trai Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth Z L 1 Court o in the past 12 months? signed by the at the detached for 2 ... No 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autonsy death? After this certificate 1 Yes 2 No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 📉 60 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Natural 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number Medical 29a. Certifie 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signatu

State Registrar Date filed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ramueller

Please Type or Print in Black Indelible Ink. Ensure All Copies Arê Cedible. 2021

		1 - State Registrar 1. Decedent's Name (First, Middle,	Last)		Ce	rtificate	e or L	Jeath		2. Date of D	Reg. No.		3. Time of	Death
Physic		Marie A. Stu								Month 5	26	2011	0850	ам
/Medi Examii		4a. Facility Name (If not institution,		ımber)		4b. City, 7	Town, or	Location o	of Death			County of Dea		
LXaiiiii		603A Laurel	Street			Poco	mok	e			Wo	orcest	er	
Funeral			6. Sex	,	yrs. last birthday,	If Under		If Under	24 Hrs. Min.	8. Date of E (Month, I	irth Day, Year)	9. Bin	thplace (State o	or Foreign
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W W		10a. State 10b. County		10	c. City, Town or L	ocation							10d. Inside Ci	ity Limits
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or 28	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What Co	ountry?	
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b	(or as a co (or as a co (or as a co tecome of pi pinth 2 anant at time own leath but no leath but no leath but no leath but no leath but no seath but no leath but no leath but no seath but no leath but no leath but no seath but no leath but no leath but no leath but no seath but no leath but no leath but no seath but no leath regnancy Fetal death 3 of death 5 ot resulting in the u 2 ER/Outpaties ar/ 28b. Time of Injury At home, farm, stripecify y knowledge, deat mination and/or in (Item 23a) (Type,	Dectopic prediction of the course of the cou	egnancy ecity) Luse give ac. Injury Work 1 1 Y office	26. Place or: 4 □ Nu at ? es 2 □ ! e, date an inion, deai	of Death	23e. Dic 1 24a. We aut per 1 Yes 1 Check only me 5 Re 28d. Describe	I tobacco u Yes 2 [Is an opsy formad? 2 [IN o one] Is idence to one injury (Street anown, State, o, date and 29d. Date	23d. Date of de Month Ise contribute to No 3 P 24b. Were a prior to death? 1 Pes 6 Other (Spe y occurred d Number or R and manner a l place, and due e signed (Month)	livery Day to the cause of corobably 4 \[\] utopsy findings completion of corobably to the cause (so the cause	Year death? Unknown available ause of	
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					ndelible ink. Ensure	-	•	00010		
			_ State		artment of Health and I <i>rtificate of Death</i>	vientai Hygie	ene [] [20317		
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	Tillicate of Death	2. Date of Death	J. No.			
	Physicia		Bennie Lee Saunders			Month May 28	3 2011 Year	3. Time of Death 12:36 P M		
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Deatl			
-	/		Prince George's Co. Hos	pital	Cheverly		,	George's		
	Funeral		4 🗆 4 4 4 4	(In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birt	hplace (State or Foreign untry) V A		
esi .	Director		225-54-3247 TXM 2 7	O Yrs.		07-26-1	940			
	show dat	호		10c. City, Town or Lo	cation			10d. Inside City Limits		
	Mary 28a-f otifie	irec	MD Prince George's	Capito	1 Heights			1 √ Yes 2 □ No		
	th the 3a or tben	Funeral Director	10e. Street and Number		10f. Zip Code	10g	g. Citizen of What Co	untry?		
	ms 2	ne	916 Shady Glen Drive 11. Marital Status 12. Was Decedent Ev		20743	US				
(O	er dez or ite niner	by Fi	11. Marital Status 1 □ Never Married 2 ▼ Married 12. Was Decedent Event Armed Forces? 1 □ Yes 2▼ N	1	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecity yes or No- Rican, etc.)	14. Race - Amer Black, White			
93	ırs aft ural", I Exal	edt	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	1 ☐ Yes 2 📉 No Specify:		Specify: Bla	ack		
Maryland 21215-0036	e filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occupation kind of work done during most of work	king 16	b. Kind of Business I	ndustry		
12	within 'giene.	Con	Elementary/Seconday (0-12) College (1-4 or 5+)	o NOT use retired) k Driver	Fo	dorol Ca	overnment		
b	be filed wental Hyg ked othe	Be	17. Father's Name (First, Middle, Last)	1 II uc		ne (First, Middle, Mai		overnment		
/lar	d be t Vienta arked atic e	은	Jessie Saunders		Lillie	Fitzgera	11d			
Jan	2 should be file th and Mental H ?7 is marked of traumatic ever		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Rur					
e, N	lealt		Addie M. Saunders/wife 20a. Method of Disposition		Shady Glen Dr.					
nor	ige 1 and nt of Hea t: If item:		1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State		natory or other place)	- 1	c. Location - City or			
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot	4	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee			and Address of Facility				
Ba	permir Depar Impor any in	J.	Fin S/ 12		•	111 PA A	20746 <u>11 PA Ave. Suitland,</u> MI			
			28a. Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line.					Approximate		
-	Ph_sician/) 6 04	Immediate Cause (Final disease or condition Fatal (Arrhythmia			Interval Between Onset and Death		
man of	Medical Examiner			consequence of):						
		er	Sequentially list conditions, b. Due to (or as a condition)	Consequence oi).						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	201100 quoti 100 01).						
	G # 15		that initiated events c. Due to (or as a c	consequence of):		.,				
09	ite be hysicia he bur	dical	d							
9289	ertifica ding p	/Me	IF FEMALE: 23c. If yes, outcome of	pregnancy						
Box	atten for us	cian	in the past 12 months?	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deli	very Day Year		
Э.	the de sy the ached	Physician/Medi	1 Yes 2 No 4 Pregnant at to 9 Unknown 9 Unknown							
P.O.	s that gned k	by P	Part II. Other significant conditions contributing to death but	not resulting in the un	nderlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?		
ds,	equires					1 🗆 Yes	2 No 3 Pro	obably 4 🔀 Unknown		
000	law re has bo	Completed				24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of		
Re	The icate r, pag		05 W			performed	d? death? XNo 1 ☐ Yes	2 🗆 No		
ita I	siciar certif recto	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:		26. Place of Death (Chec.	k only one)				
of \	a Phy er this eral d	e: To	27. Manner of Death 28a. Date of injury		t 3 🗆 DOA 4 🗆 Nursing Ho	ome 5 L Residence 28d. Describe how in	e 6 Other (Specit	5/)		
Division of Vital Records,	anding ath. ir: Afte	Certificate:	1 Natural 5 Pending (Month, Day,) 2 Accident Investigation	Year) injury	work? M 1 ☐ Yes 2 ☐ No					
Visi	or Atte fter de irecto n by tl	erti	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (- At home, farm, stre	eet, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,		
				0 1			- "			
	P Hos	Medical	29a. Certifier 1 Certifying Physician: To the best of my (Check only one) 3 Certifying Murse/Practioner: To the basis of examiners only one) 1 Certifying Murse/Practioner: To the basis of examiners only one) 2 Certifying Murse/Practioner: To the basis of examiners only one) 3 Certifying Murse/Practioner: To the basis of examiners only one) 3 Certifying Physician: To the basis of examiners only one of the basis of examiners on the basis of examiners of examiners on the basis of examiners on the basis of examiners of exam	mination and/or investi	igation, in my opinion, death occurred a	the time date and n	lace and due to the ca	ause(s) and manner stated		
	To the comp		29b. Signature and title of certifier	z. or yely knowledge, di	29c. License number		Date signed (Month,			
	,		· / // ///	1	D65367		June 10, 2	2011		
)	5		30. Name and address of person who completed cause of deat		rint)					
			Mehdi Sattarian MD 3001 Hos	spital Dri	ve Cheverly, Md.	20785				
	State Registra	e r	31. Date filed (Mosth Day, Year) 32. Registrar's	perker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2011 2:50 a.m. Tiburzi Amy June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Hours (Month, Day, Ye 2 / 25 / 19 Min Director 187-18-7700 89 Maryland Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Tes 2 No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 45927 Rolling Road 20653 United States 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🖾 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Albert Woodburn Bertha Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45927 Rolling Road, Lexington Park, MD James Tiburzi/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 06/17/2011 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licen M01403 20650 anielle Hollywood Road, Leonardtown, MD Ward 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition ardiac 1 nutes Medical resulting in death) Due to (or as a consequence of): Examiner VOOYIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit -ntman that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Month Pregnant at time of death 5 Other (specify) s been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA funeral . Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatle Funeral Director: 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 006842 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month

JUN 1 7 2011

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State Registrar	Maryland / Depa <i>Cer</i>	artment of F tificate of E		Tental Hygle Reg. 2. Date of Death		20321		
	Physicia		1. Decedent's Name (First, Middle, Last) John Mason Taylor					Day2011 Year	3. Time of Death 4:00 am _M		
		Medical Examiner 4a. Facility Name (If not institution, give street and number) Renaissance Gardens at Riderwood Village			4bSM Gwror Spirot of geath			4c. County of Dea Prince Ge	orges		
	Funeral Director		043 21 3370 FEM 20F	Age (In yrs. last birthday) Yrs.	In yrs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			9. Bir	Birthplace (State or Foreign Country) T		
M	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I firem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ector	Usual Residence of Decedent 10a. State 10b. County MD Montgomery	10c. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 No		
Baltimore, Maryland 21215-0036		Funeral Director	10e. Street and Number 6 Over Ridge Court		10f. Zip Code 20854		10g	. Citizen of What Co USA	ountry?		
		To Be Completed by Fur	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 12. Was Decede Armed Force 112. Was Decede Armed Force 113. ☐ Yes 2 114. Was Decede Armed Force 115. ☐ Yes 2 115. Yes 2 116. Yes 3 116. Yes 4 116. Yes 5 116. Yes 5 116. Yes 5 116. Yes 5 116. Yes 5 116. Yes 6 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 8 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 8 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 8 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 7 116. Yes 8 116. Yes 7 116. Y	7953-1957	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 ĀNo	ispanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	e, etc.		
			15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 5-College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plant Pathophysiologist U.S. Dept								
	d be filed v Mental Hyg arked othe atic event,		17. FMason Keburn Paylor			18. Mother's Name Martha W	e (First, Middle, Maid aller Mas	len Surname) ON			
	Page 1 and 2 should tment of Health and N tant: If item 27 is ma jury or other trauma		19a Informant's Narchelationship (Ton Eriphaug Martha Ellen	Poto	mac, MD		l Route Number, Cit				
			20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	Cremator	netery of other place. A	June	10,2011	a. Location - City or Alexandri	La, VA		
Ba	Depar Impor any ir		21. Signature of funeral Service Lichtee					Silver S	pring,MD 2090		
*	nysician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End—Stage Dementia Tyr Pure to (or one a consequence of):								
	Examiner	ier	Arteriosclerotic Coronary Artery Disease 1 yr								
3760	cate be executed physician and s the burial-transit	edical Examiner									
	ificate be ng physic as the bu		d			<u> </u>	-	1			
. Box 68	requires that the death certific been signed by the attending should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	elivery Day Year							
ls, P.O.	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	δ	Zare II. Other significant conditions continuously to death but not resulting in the underlying season given in tare.								
Record	The law ate has page 2	Completed					24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of s		
Division of Vital Records, P.O. To the Brenital or Attanding Physician: The law requires that the	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 I le		Oth	ace of Death (Checker:					
	nding Phys th. After this funeral di	cate: To	27. Manner of Death A Natural 5 □ Pending (Month, 2 Accident Investigation)	work	28c. Injury at work?		me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
Divisio	To the Hospital or Attending Physiciam: within 24 hours after death and the funeral Director. After this certification pleted filled in by the funeral director.	l Certificate:	2 Suiside 6 Could not be				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	he Hospit in 24 hou he Funer: pleted fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
	To t with To t		29b. Signature and title of certifier	th, Day, Year)							
1.	f		30. Name and addless of person who completed cause Julatine Harding, CRNP	of ceath (Item 23a) (Type, F 3110 Grace	Print)	ad, Silve:		MD 20904			
T	Sta		31. Date filed (Month, Day Year) 3 2011 32. Beg	jistrar's Signature	Sarke						

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ D. Conth 125A Hilary Matthew Taylor Jr. Medical Facility Name (if not institution, give street and number 4c. County of Death **Examiner** O ICOM Social Security Number Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav 8. Date of Birth **Funeral** Days Hours 1 🛛 M 2 🗆 F Months Min 07408 P1928 MaryTand 82 215-20-4790 Yrs Director Usual Residence of Decedent show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 USA 516 Pine Bluff Rd 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married þ If Yes, Give Air Force Year or Dates. しか しず ナイロン Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Insurance Company District Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Hilary Matthew Taylor Sr. Hattie Byrd Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21801 516 Pine Bluff Rd., Salisbury, Phyllis Taylor wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial

Wicomico Memorial 05 11 2011 Salisbury, Maryland Park 22. Name and Address of Facility Holloway Funeral Home P.A. 21. Signature of Suneral Service License Maryland 21804 Snow Hill Rd., Salisbury, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) bunal-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? within 24 hours after death.

To the Funeral Director: After this certificate ☐ Yes Yes 2 L or Attending Physician: 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Tother (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 \square No Investigation 6 Could not be Accident filled in by the 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signati 29d. Date signed (Month, Day, Year) CTC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IVA ASTERN SHORE DK, SAUSBURY MD 21804 egistrar's Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SHIRLEY TAYLOR 7:20 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peninsula legional xilisbur WICOMICO Madial Conta If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign 1 M 2 SKF Hours Min Country Maryland 221-22-6402 73 M2th/12791937 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Delaware Sussex Delmar 1 Yes 2 ☐ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a on the Medical Examiner must be Funeral 200 Holly 19940 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates white 1 ☐ Yes 2 ☐XNo Specify. Specify: 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Lab Tech Chemical is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental မ Samuel Jerolaman Elsie Mae McCalister Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Randy Taylor - son 3317 Sharon Ct, Federalsburg, MD 21632 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Blades Cemetery 06/13/2011 Blades, DE 4 Donation 5 Other (Specify) 21. Signature of Funeral Project Lice we John A. Cranston 22 Name and Address of Facility Cranston Funeral Home any O Box 967, DE 19973 Seaford, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling.) Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ vermon 1 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iirijury Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): completed filled in by the funeral director, page 2 should be detached for וואף איי בייייים. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mellitus Completed 1 Yes 2 No 3 Probably 4 Unknown after death.

Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 1 ☐ Yes 2 ☐ No 24 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 🖳 🗸 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 £. Carroll St. Acle rernando m.D. COP. R.M.C Salisbury

State Registrar 31, Date filed (Mo

Registrar's Signature

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		State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.								6996			
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win	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death										
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Marical Examination to other traumatic event, it a Marical Examination to other traumatic event.		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits	
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		ral	5956 Tappan La		***	,	22002			USA			
36		by Funeral Director	 11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced 	12. Was Deceder Armed Forces 1 Tyes 2 If Yes, Give Year or Dates	s?]No Marin		Vas Decedent Yes, specify □Yes 2 K	t of Hispanic Origi Cuban, Mexican, No <i>Specify:</i>	n? (Specify Yes o Puerto Rican, etc.	r No-)	14. Race - Ame Black, White Specify:	e, etc.	
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	tal Hy d othe	Be C	17. Father's Name (First, Middle, L	ast)					s Name (First, Mi	ddle, Maider	Surname)		
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Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 ☐ Removal from Stat	20b. Pla St.e	ce of Dispos	sition (Name o		Date	20c. L	ocation - City or Cago, I	Town, State	
Balti			21. Signature of Funeral Service L		e	HO 50	Name and A	ddress of Facility Funeral Hill Rd	Home P.	A. burv,	Marvlan	đ 21804	
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	10,10		30. Name and address of person w	TRAGITE	ms	1665		BROOK	DE SAL	SBUR	y MD 2	21804	
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Year Physician/ verett 2011 08:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ninsula Realonal Medical Salisburi Nicomico If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 **X**M 2 □ F Months Hours Director OHIO 28a-f show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 No ccamac 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural", Completed 3 Widowed 4 Divorced th and Mental Hygiene.
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To the Funeral Director: After this certificate has been signed by the attending physician and -transit that initiated events Due to (or as a consequence of): resulting in death) Last the burialthe attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Month 4 Pregnant g Unknown Day Year Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 -No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed' 2 🗌 No ☐ Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 -No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work 1 Tyes 2 No s after death. I Director: ∤ Accident Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 06-04-2011 D66 111 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. Carroll St. Salisbury MD. mc Cutcheon, Brion C m.D P.P.M.C. 32. Registrar's Signature State 6 Registrar

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Jeanette Towns	senc	1- For State Registrar		tate of Mary		partmen e <i>rtificate</i>			id Ment	al Hyg		Reg. No.		20020
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Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or nither tr	/	Jonation 5 Other Specify: Veteran's Cemetery 5-6-2011 Millsboro, DE 21. Signature of Funeral Service Licensee Pennie Smith 917 W. Isabella St. Bennie Smith												t.
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Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	edical C			nysician: To the besing miner: On the basis and manner s	of examination									
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			For State		State o	f Maryl	and / Dep	artmen <i>tificate</i>			and M	lental Hy	giene	2011	20327
			Registrar 1. Decedent's Name (Firs	t Middle I ast)		_	Cei	uncau	e OI D	eain		2. Date of De	Reg. No).	2 Time of Donath
	Physicia			am Turp	in							Month	Da		3. Time of Death 13:36 PM
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	Funeral		5. Social Security Numbe	r 6. Sex	7		rs. last birthday)	If Under		If Under	24 Hrs. Min.	8. Date of Bir	th		Birthplace (State or Foreign
	Director		214-30-7789	7	M 2 □ F	81	Yrs.	Months	Days	Hours	IVIIII.	(Month, Da 4-1-1	930	Ĭ	ountry) Delaware
	now at	_	Usual Residence of Dece 10a, State 10b.	dent County		100	City, Town or Lo	cation					-		10d. Inside City Limits
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	or 28	Ë	10e. Street and Number					10f. Zip	Code				10a. Ci	tizen of What 0	Country?
	tth with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	14377 Shila	h Way					19956	6				USA	,
	death v items ner mu	표	11. Marital Status		2. Was Deced		U.S. 13.				jin? (Spec	cify Yes or No- Rican, etc.)		14. Race - An	nerican Indian,
36	ifter of ", or a	ρ	1 Never Married 2		Armed For 1 X Yes If Yes, Give	2 No		Yes			, Puerto F	ncan, etc.)		Black, Wh	ite, etc. V hite
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Completed by	3 Widowed 4 1	Parameter Contract	Year or Dat	tes.				are					
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þ	illed vall Hyg	Be	17. Father's Name (First, I	Middle, Last)				, cilia				(First, Middle,		_	AILIMITATI
/lai	d be Menta arked	2	Donaldson T	urpin							Hele:	n Bagor	nia		
Maryland	shoul and l is ma		19a. Informant's Name/R	elationship (Type	e, Print)		19b. Mailir	ng Address	(Street ar	nd Numbe	r or Rural	Route Numbe	r, City or	Town, State, 2	Zip Code)
	ind 2 fealth im 27		Daniel Turp		n)					lock :	Rd. I	Weston,	F1	ordia 3	33327-1216
Baltimore,	permit. Page 1 and 2 should be filled within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once.		20a. Method of Disposition 1 D Burial 2 X Cre		emoval from S	State	 b. Place of Dispo cemetery, crer 	natory or o	ther place		D	ate	20c. L	ocation - City of	or Town, State
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Ba	permit Depar Impor any in		21. Signature of Funeral S			nigo	.)	. Name an		,			T II		lest St.
			()	Ba. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardin										. Laure	Approximate
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	Physician/ Medical		disease or condition resulting in death)	a.	Due to (c	r as a cons	sequence of):	Acc) D						~
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687	eath certifica attending ph for use as th	N/	IF FEMALE: 23b. Was decedent pregn	ant 23	c. If <u>ye</u> s, outc	ome of pre	gnancy							23d. Date of d	leliven
Box	eath e atte	icia	in the past 12 month 1 ☐ Yes 2 ☐ No		4 🔲 Pregn	ant at time	etal death 3 C of death 5 C	Ectopic p Other (sp		·			Ì	Month	Day Year
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P.0	requires that the der been signed by the s should be detached	Completed by Physician/Me	Part II. Other significant	conditions cont	ributin g to de	ath but not	resulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	obacco u	use contribute	to the cause of death?
'ds	equire sen si ould b	ted										1 🗆	Yes 2	□ No 3 □	Probably 4 M Unknown
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ital	ician certifi rector	m	25. Was case referred to r examiner? 1 ✓ Yes 2 ✓ No		spital:				Louis	ce of Death 	h (Check	only one)			
of V	ding Physician: The land. After this certificate hand funeral director, page	<u>و:</u>	27. Manner of Death		28a. Date o	f injury	ZER/Outpatier 28b. Time of		Bc. Injury	4 LI Nui		ne 5 🗌 Resid 8d. Describe h		Other (Spe	ecify)
n C	nding ath. :: Afte e fune	cat	1 Natural 5 2 Accident	Pending Investigation	(Month	, Day, Year,) injury	M	work?	′es 2 🗆 i	1	od. Decombe i	iow injur	y occurred	
Division of Vital Records,	I or Attendation after deat Director:	Certificate:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined			t home, farm, stre	et, factory,	office		2				Pural Route Number,
Ö.	spital or Attene ours after deat eral Director: filled in by the	<u>8</u>			Dullaine	g, etc. (Spe	спу)					City or Tou	n, State,)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 🔀 M	edioal Examine	r: On the basis	of examina	owledge, death out	igation, in n	ny opinion	, death occ	curred at t	he time, date a	nd place	, and due to the	e cause(s) and manner stated.
	To the Hos within 24 h To the Fun completed		only one) 3 7 A	ertifylng Nurse	Practioner: To	the best of	f my knowled g e, c	eath occur	red at the	time, date	and place	, and due to the	e cause(s	s) and manner a	as stated.
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U	\\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	ł	30. Name and address of	Derson who con	pleted cause	<u> </u>	tem 23a) (Time P	rint)	, , , ,	11/			915	1-	
	11/12		CHRIS SNY			SME	100	ε. Co	rro	11 51	4	Salis	hin	an M	d 21801
	Stat		31. Date filed (Month, Day,	Year) 2011		gistrar's Sig	nature	· Med			-			71	
	Registra	ır	JUN	A 2 TO 1	14	w	P- 190								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06 Day 05 2011 Physician/ Upton James 12:0511 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** COASTAL HOSPICE AT The SALISBUR NICOMICO . Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Days 219-14-0955 Months Hours (Month, Day, Year) 05/22/1924 Director 87 Maryland Usual Residence of Decedent or items 23a or 28a-f shov miner must be notified at 10b. County 10c, City, Town or Location with the Maryland 10d, Inside City Limits Director 1 Tyes 2 X No Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27829 Chesterfield Lane 21801 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner. Armed Forces?

1 Yes 2 No Black, White, etc. ğ 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Alonzo Upton Carrie Biles 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Dennis/daughter 27829 Chesterfield Lane, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/7/2011 Salisbury Crematory Salisbury, MD . Sign we of Funeral Service Licensee ²²Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1200 2 Medical resulting in death) Due to (or as a conse meno Examiner Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death ☐ Yes _ _ ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 KNatural work 1 🗌 Yes 2 🗀 No Accident Investigation completed filled in by the 6
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🗸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 06-05-2011 . Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIC M. BELLOSC 5302 CHINABERRY DR. SALISBURY MD 2180 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Co Mia Christine Vye 9:40 PM Medical Eqcility Name (if not institution, give street and number **Examiner** 4c. County of Death (10astal) DSDICE. DICOMICE 5. Social Security Number If Under 24 Hrs 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF June 5, 1952 566-92-3822 59 Washington DC **Director** Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s her must be notified 1 X Yes 2 □ No Maryland Wicomico Salisbury 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1313 Spruell Drive 21804 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 þ 1 X Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 1 Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) the Administrative Assistant University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of r other traumatic ever ပ Murvyn Wesley Vye, Jr. Mary Christine McSteen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Margaret F. Genvert/Friend 1111 Cotton Patch Island, Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Springhill Mem. Gard. 6/14/2011 4 Donation 5 Other (Specify) Hebron, Maryland of Funeral Service Like 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, 1. Enter the disease, or com vications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one Interval Between Immediate Cause (Final Onset and Death Physician/ CARCINDING disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \(\subseteq \text{ No} \) 5 Other (specify) Month Day Year 9 Unknown ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law thin 24 hours after death. Director: After this certificate has autopsy performed2 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: HOSPIGE မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specif Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a 14 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Numer Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the nave stell and mark or as stated 29b. Signature and title of certifier 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a Human V 1380 31. Date filed (Month, Day, Year) egistrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nathan Emory Workman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Western MD Regional Medical Center Allegany Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Director 215-36-9754 83 March 17, 1928 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Allegany Frostburg 1 Yes 2 No 10e. Street and Number ò 12500 Old Legislative Road 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 21532-U.S.A. hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Clarence O. Workman **Margaret Smouse** other traumatic 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If Item 27 is any injury or other transconce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Workman Wife 12500 Old Legislative Road 21532-Maryland Frostburg Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cumberland Crematory June 08, 2011 Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 4ntraceres bleed disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading 1 minutes cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami -transit Hospital or Attending Physician: The law requires that the death certificate be executed and e attending physical and a street burial-tr resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month s been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy perform this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 24 hours after death. Funeral Director: A Accident Investigation completed filled in by the Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified R088399 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

CONNIE JO

12501 Willow BROOK Rd Cumberland

	_		For State Registrar	Stat	e of Ma	aryland	•	artmen <i>tificate</i>			and M	lental Hy	giene Reg. No	2111	When the American	20331
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	uneral irector		214-32-6250	. Sex 1 □ M 2 🛭	7. Age	e (In yrs. last 74		If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bit 10-27-	th 1936	5		place (State or Foreign try) Land
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shou	7 is n	14	19a. Informant's Name/Relationship			- 1		-				Route Numbe				<i>*</i>
and 2	her t		Tasha Werkheise	<u> - Gra</u>	anddaı					Hill						
96 1 g	or of		20a. Method of Disposition 1 ↑ Burial 2 ☐ Cremation 3	Removal	from State	20b. Plac	ce of Dispos netery, crem	sition (Name atory or ot	e of her place	e)	D	ate	20c. Lo	ocation - Ci	y or To	wn, State
t. Paç tmen	tant		4 ☐ Donation 5 ☐ Other (Spe	cify)		Spri	nghil	1 Mem	ory	Gds	6-14	-2011	Heb	ron,	Mar	yland
partment of Department of	Impor any in		21. Signature of Juna al Service Lice	Bely	Bla	rpe	- 1	Name and			, D	ounds , Sali				and 21804
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications t	hat caused	the death. I	Do not ente	r the mode	of dying	, such as	cardiac or	respiratory ar	rest,			Approximate Interval Between
Phy.	sician/		Immediate Cause (Final			/)										Onset and Death
	ledical		disease or condition resulting in death) a. CHRONIC WASTING SYNDROME Pure to form a consequence of the control of the cont													
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-	±	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): CHRONIC RESPIRATORY INSUFFICIENCY													
te be executed	trans	хап	that initiated events	c				KES,	PIRA	TOR	1	INSUF	PICIE	NCY	- 1	
e exe	ian a	alE	resulting in death) Last	Due	e to (or as a	consequen	ice of):									
ge P	attending physician and for use as the burial-transit	dic	•	d				<u> </u>							+	
	ing p e as t	/Me	IF FEMALE:	00- 16												
Attending Physician: The law requires that the death certifica or death.	ttend or us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 🔲 l	Live Birth 2	of pregnancy 2 Fetal d	eath 3	Ectopic pr		,				23d. Date of		*
3 eg	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Pregnant at Unknown	time of dea	ıth 5∟	Other (spe	cify)					Month		Day Year
at th	signed by the s be detached f		Part II. Other significant conditions	contributing	to death bu	ıt not resulti	ina in the ur	nderlying ca	ause give	en in Part	l.	23e Didt	obacco u	ise contribu	te to th	e cause of deatba
res th	signe I be o	d by					J	, 5	5							pably 4 Unknown
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a N	has le 2 s	ᇤ										24a. Was			r to con	sy findings available npletion of cause of
. T	icate h		OF Was a second second by the last	_								1 🗆 Yes				2 🗆 No
iciar	recto	B B	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	Hospital:					Othor		th (Check	only one)				
Phys	r this certifica eral director, p	2	27. Man r of Death		 Inpatie Date of Injury 	nt 2 ER	VOutpatient Bb. Time of		c. Injury	4 ∐ Nı		ne 5 🗹 Resid			(pecify	
ding.	age of	gte	1 ✓ Natural 5 ☐ Pending	(1	Month, Day,	Year)	injury	M Z	work?			Bd. Describe I	iow injury	occurrea		
deat	rector: After in by the funera	Certificate:	3 Suicide 6 Could not	be 280 P	lace of Injur	y - At home	e farm stre			- 2	_	8f Location (9	Stroot and	ANumbero	- Dural	Route Number,
after	Dire	ပြီ	4 L Homicide determine		uilding, etc.		, , , , , , , , , , , , , , , , , , , ,	ot, 140tory,	011100		'	City or Tov			nurar	noate Namber,
To the Hospital or Attendi	To the Funeral Dir completed filled in	Medical	29a. Certifier 1 Certifying Pl	ıysician: To ti	he best of n	ny knowled	ge, death o	ccured at the	ne time,	date and	place, and	due to the ca	use(s) an	d manner a	s stated	d.
n 24	ne Fu	Med	(Check 2 Medical Exa only one) 3 Certifying No	miner: On the	basis of exa	amination ar	nd/or investi	gation, in m	y opinion	n, death o	curred at t	he time, date a	and place,	and due to	the cau	se(s) and manner stated.
To th withii	To th	_	29b. Signature and title of certifier	-			J		License	-				e signed (M		
	61		Faux plu	pi		M)		1	38	647				06-0	9-	2011
	2		30. Name and address of person who	completed	cause of dea	ath (Item 23	a) (Type, Pr	int)								
	フ		6 1/	9214		325	M	7. 1	HER!	New	Ro,	SALI	SBUR	24	ND	21804
	Stat	·E	31. Date filed (Month, Day, Year)		2. Registrar	's Signature		7. /								
F	Registra		JUN 10 2	$\Pi \sqcup \mathcal{L}$	Elm.	A.	ba	MA								

		_	For _ State	State of I	Maryland / De			vlental Hyg	iene	20332
			Registrar		Ce	ertificate of L	<i>Death</i>	1	eg. No.	
	Physicia	n/	Decedent's Name (First, Middle	,				2. Date of Deat Month	2011 Year	3. Time of Death
	Medic	al	Timothy	<u>E</u>	Α.	We11		June 8,		9:15 A M
	Examin	er	4a. Facility Name (if not institution)		7		r Location of Death		4c. County of Dea	
	Funeral		6625 Whitesburg 5. Social Security Number		Age (In yrs. last birthday	Snow H		8. Date of Birth	Worcester 9. Bir	tholace (State or Foreign
	Funeral Director		213-44-7153	1 ፟ M 2 □ F	64 Yrs.	Months Days	Hours Min.	Sept. I	Year) 946 Wasi	hington, D.C.
	- 10		Usual Residence of Decedent						-,17 1100	
C	sho	ġ	10a. State 10b. County		10c. City, Town or	_ocation				10d. Inside City Limits
Mon	otifie	<u>ie</u>		omico	Parson					1 ☐ Yes 2 🏝 No
4	ben		10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Co	ountry?
4	ms 23	Funeral Director	33279 Bob Smit			218			USA	
70	r iter		11. Marital Status1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Forces	nt Ever in U.S. s? □ No 1964-	 Was Decedent of H If Yes, specify Cuba 	ispanic Origin? (Sp an, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
	al", o	d b	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	1000	1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
5	ical E	Completed	15. Deceder	nt's Education	16a, Dec	cedent's Usual Occup	ation		16b. Kind of Business	Industry
2 2	an "r Med	E C	(Specify only higher Elementary/Seconday (0-12)	st grade completed) College (1-4 c	life	re kind of work done of DO NOT use retired)		king		,
7	giene er th		12			ireman			Fire Depa	artment
ב ב	d oth	o Be	17. Father's Name (First, Middle, L	ast)			18. Mother's Nan	ne (First, Middle, N	faiden Surname)	
<u>ya</u>	Ment	욘	Urbey	E	We	211s	Isabella	a	S1	tokesbury
ום. יים	raum		19a. Informant's Name/Relations		i i i	-			City or Town, State, Zi	ip Code)
בי נו	if hand 2 should be filed within 72 flodds after beart with the way yand if hand 2 should be filed by the filed of the filed by the filed of the filed by the filed by the filed by the filed by the filed by the filed at other traumatic event, the Medical Examiner must be notified at		Patricia Wells 20a. Method of Disposition	Canfield-		26 63rd Sq position (Name of	. Vero B			-T Ot-t-
5	nage in		1 Burial 2 Cremation		ate cemetery, ci	ematory or other plac	i i		20c. Location - City or	
	irtmei irtmei irtani njury		4 Donation 5 Other (S			ry of Deln 22. Name and Addre			Delmar, De	laware
מ	Department of Department of Important: If it any injury or conce.		21. Signature of Funeral Service	DOOI BE	/	705 E Main			neral Home	
		Н	23a. Part 1. Enter the disease, or	commications that caus	sed the death. Do not e					Approximate
DI	n sician/		shock, or heart failure. List of immediate Cause (Final	nly one cause on each I	line.					Interval Between Onset and Death
	Medical	1	disease or condition resulting in death)	a. HINER	OSCLER-07	(C CARI)	OVASCUL	ALC DI	SEASE	
E	xaminer					F LUNG.				
		ner	Sequentially list conditions, if any, leading to immediate	D. —	as a consequence of):					
her	ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	с						
Daxa	ian ar ırial-tı	<u>m</u>	resulting in death) Last	Due to (or a	as a consequence of):					
3 4	attending physician and for use as the burial-transit	dical		d						
و ا	ling p	/Me	IF FEMALE:	23c. If yes, outcom	no of programov					
7 4 d	attenc for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live Birt	th 2 🗌 Fetal death 3	Ectopic pregnand	су		23d. Date of de Month	elivery Day Year
و ق	the	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗆 Unknow						
בי לבי בי לבי	ed by deta	by Pt	Part II. Other significant condition	ns contributing to deat	h but not resulting in the	e underlying cause gi	ven in Part I.	23e. Did tob	pacco use contribute to	o the cause of death?
, in	sign Id be	g p∈						1 □ Y	es 2 🗆 No 3 🗆 F	Probably 4 Onknown
	s been	Completed						24a. Was a		utopsy findings available
	te has	mo						autops perform	med? death?	completion of cause of
- in	rtifica tor, p	Be C	25. Was case referred to medical			26. P	lace of Death (Chec		2,24,10)	2 24110
VIC	lis ce direc	10	examiner? 1 Xyes 2 ☐ No	Hospital:	eatient 2 ER/Outpat	ient 3 🗆 DOA Oth	er: 4 Nursing H	ome 5 🗆 Reside	ence 6. Other (Spec	city) ASST LIVING
5 2	fter th	ate:	27. Manner of Death 1 Natural 5 Pendir	28a. Date of i	njury 28b. Time <i>Day, Year)</i> injury	worl	< ?	28d. Describe ho	w injury occurred	,
VISION	leath. tor: A	ifica	2 Accident Investig	gation			Yes 2 No			
2 2	within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	4 Homicide determ	ined 28e. Place of	Injury - At home, farm, etc. (Specify)	street, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ural Route Number,
<u>ה</u>	ours a	Medical	29a, Certifier 1 *Certifying	Physician: To the best	of my knowledge, deat	h occured at the time	e, date and place, a	nd due to the cau:	se(s) and manner as st	ated.
1	n 24 h	Medi	(Check 2 Medical E		of examination and/or inv	estigation, in my opini	on, death occurred a	at the time, date an	d place, and due to the	cause(s) and manner stated.
5	withi To th		29b. Signature and title of certifier	-1 -		29c. Licens		2	29d. Date signed (Mont	
			▶ Zut	M. M.		D 62	172		6/9/2011	(
3	Tova		30. Name and address of person SHALAD R	SAMAL, MI	f death (Item 23a) (Type) (604 /	u, Print) UARKET	ST. POL	OMOKE	City MD	21851
	Stat Registra		31. Date filed (Month, Day, Year)	2011 37 Regis	strar's Signature	and				
	negistic		4411 # 2		- P. A					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Sarah Louise Waters 0732 M Ti 201 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death nins ICCM Madical Center almal Social Security Numbe 8. Date of Birth (Month, Day, Year) April 16,1923 If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 1 M 2 F Months Min **Director** 062-20-2772 88 Usual Residence of Decedent 28a-f show 10a. State within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6933 Scotland Road 21863 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc.
Africanģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. Completed 3X Widowed 4 □ Divorced Year or Dates American the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 11 Short Order Cook Convenience Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Chester Eleanore Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laverne Dennis-Cropper/cousin 6937 Scotland Road, Snow Hill, MD 21863 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Mt. Wesley UMC Cem 6/7/2011 4 ☐ Donation 5 ☐ Other (Specify) Snow Hill, MD 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Lewis N. Watson Funeral Home, PA 1618 West Road, Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Multiorgan dysfunction syndrome Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of): ischemic colitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury use as the burial-tran been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 2 No 1 Tes Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Matural injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 00070961 276 on who completed cause of death (Item 23a) (Type, Print) 100 E. CARROLL ST.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Evelyn Wheeler Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery <u>Washington Adventist Hospital</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 💆 F Hours Min $Ju_{\perp y}^{(Month_1Day, Year)}944$ Director 578-60-5200 66 DC Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Fort Washington 1 X Yes 2 ☐ No Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20744 United States 317 Aragona Drive 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced American Year or Dates the Medical 15. Decedent's Education 16b. Kind of Business Industry
Prince George's County 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) . Page 1 and 2 should be filed within 72 treet of Health and Mental Hygiene tant: If item 27 is marked other than 'iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Court House 11th Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernice Williams Roosvelt Jefferson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9733 Williamsburg Drive Upper Marlboro, Md. 20772 Lorraine C. Champ - Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Brentwood, Maryland Signature of Fune Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 2 a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year Day 5 Other (specify) 1 ☐ Yes 2, ☑ 9 ☐ Unknown 9 Unknown Part II. **Other significant conditions çop**tributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 2 🗆 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 🗌 No Other: ٩ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 -Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The Certifying Presentations: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

State Registrar

30. Name and address of person

31. Date filed (Month, Day, Year,

ANNA

ACHTCHIWINA, M.D.

760C Carroll Avenue

Takoma Park, Md.

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JÜNE Wilson 18๊ 2C11 Annetta 7:20P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Boonsboro Washington Reeders Memorial Home Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign 1 M 2 XF Hours 220-18-1587 Feb. 14 Year 1925 Mary Tand 86 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Frederick MD Frederick 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 21702 10g. Citizen of What Country? United States 1421 Taney Avenue Apt. 622 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 XWidowed 4 ☐ Divorced Year or Dates Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o ဂ္ Raymong Goodsell Fannie Bere 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Wilson (Son) P.O. Box 464, Keedysville, MD 21756 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 6/21/2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}d P.A. Funeral Home Keeney & Basford P.A. Funeral Home 106 E. Church St., Frederick, Maryland 21701 23a. Part 1: Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, MO1612 shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ TO LIVER AND CANCEN. disease or condition resulting in death) METHSTANK monye Medical Due to (or as a consequence of). Examiner STAGE MOWNEJ. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that in the cause or impury that in the cause or impury that in the cause or impury that is the cause or impury that is the cause or impury that is the cause or impury that is the cause or impury that is the cause or impury that is the cause or impury that is the cause or impury that is the cause of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi MONTHS -DEBILITY that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death 1 Yes 2 No 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this nours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 ☐ Accider 3 ☐ Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 146561 20 SM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GHAZALA QADIR, 20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713 301-432-8470

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

2 4 2011

AC

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 20 Ronald George Wilson 06 2011 9:14 a 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 11105 Upper Georges Creek Road Allegany Frostburg Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Months Days Hours Min 69 Mary land 214-42-0292 10-18-1941 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits **Allegany** Frostburg 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11105 Upper Georges Creek Road 21532 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Nes 2 No 966 1 Yes, Give Year or Dates: 1668 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Steel Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William P. Wilson Viola Barnes Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19108 Old Dans Rock Rd., Frostburg, MD 21532 Sharon Wilson 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Cumberland Crematory 06-21-2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home, Sow 43 161 M00547 60 W. Main St., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTI ORGAN SYSTEM FAILURE disease or condition resulting in death) Due to (or as a consequence of): WNE CANCER META STATIC Cequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? COPD 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown CHF 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Director

Funeral [

ρ

Completed

Be

2

MD

Examiner

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evenilest must be 1 citified at once.

Baltimore, Maryland 21215-0036

Examiner burial-tran physician a Physician/Medical attending p Completed by Be Certification: To

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

(Check only one)

29b. Signature and title of certifier

or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the rector, page 2 should be detached funeral director, After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

Division of Vital Records, P.O. Box 68760,

State Registrar

Medical

CARISSA 31. Date filed (Month, Day, Year)

CARISSA

5 Pending investigation

6 ☐ Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day, Year)

M.D

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

00069419

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1313 National Hwy LaVale MD 21502

VEA,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		for State Registrar	State of Mary		epartment of F Certificate of I		ientai Hygier Reg. r	1 1 1	(10331
Physici		1. Decedent's Name (First, Middle, Las Stantey	Toseph	つ.	4 tor		2. Date of Death	Day Year	3. Time of Death 0210 _M
/Medic Examin		4a. Facility Name (If not institution, give	street and number)			Location of Death		4c. County of Death	
Funeral Director		5. Social Security Number 6. S 148-01-6855		yrs. last birth Y	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea Oct. 17,1		ace (State or Foreign try) Jersey
Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Anne Aru		c. City, Town			<u> </u>	10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
h with the 23a or 28a st be notif	al Director	10e. Street and Number 284 Raintree Dri	ve		10f. Zip Code 21	012		Citizen of What Coun	Iry?
ING 21215-0036 be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, it a Modical Examination at the mellined at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	I DE 162 Z INO	in U.S. 1941 – 1945	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: Whi	etc.
Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mental Hygiene. t? is marked other then "natural", or traumatic event, the Medical Exerca	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Decedent's Usual Occup Give kind of work done life. DO NOT use retired Machinist	durina most of worki	ing	Kind of Business/Ind	•
and 2 be filed tal Hygi od other event, 1	To Be Co	17. Father's Name (First, Middle, Last)		1 1	unk	18. Mother's Name	(First, Middle, Maid		тректу
lore, Maryla ges 1 and 2 should t of Health and Men If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Lillian Sasko /Si			Mailing Address (Street) 4 Raintree				Code)
Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery	Disposition (Name of crematory or other place Crematory ,	🤲 ¦ June	07,	Location - City or To	
Baltimo permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licen			Barranco & 495 Ritchi	e Hwy,	Severna	a Park Fun a Park, MD	21146
Physician /Medical		23a. Part1. Inter th Clis ase, or com, shock, or hear inlure. List only Immediate Cause (Final disease or condition resulting in death)		105	elerot			Seasil	Approximate Interval Between Onset and Death
Examiner	Examiner	Sequentially list conditions, it any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	nsaquenca al):				
68 / 60, ificate be executed physician and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as a cor	nsequence of):				
death cert e attending	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pri 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	,		23d. Date of delive Month	ory Day Year
S, 1	þ	Part II. Other significant conditions o	ontributing to death but no	t resulting in	he underlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to the	ne cause of death?
The law The law ate has b	Completed						24a. Was an autopsy performed	? prior to con death?	psy findings available inpletion of cause of
OT VITC	To Be	25. Was case referred to medical examiner? 12. Ves 2 \(\triangle \text{No} \) 27. Manner of Death	28a. Date of Injury	28b. Ti		er: 4 🗆 Nursing Ho	me 5 Residence 28d. Describe how in	6 □Other (Specify	1)
DIVISION (I or Attending Fatter death. Director: After I in by the funer.	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		At home, farr		Yes 2 □ No	28f. Location (Street City or Town, St	and Number or Rura ate)	I Route Number,
Hospita 4 hours Funeral ely fillec	edical C		ysician: To the best of my niner: On the basis of exar and manner stated.						
To the I within 2. To the I complet	Me	29b. Signature and title of certifier	RAS	epu w	29c. Licens	o number	54 29d.	Date signed (Month, I	Day, Year)
3-1W		Milliam 1	completed cause of death 2. Registrar's S	13	ype, Print)	695	Amor	KA &	1035
Sta Registr	re ar	31. Date filed (Month, Day, Year) JUN 0 8 2017	Berown	A. A	race				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FRONICA 21:28 PM ALLIEGIPO JUNE 2011 24 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day Year) If Under 1 Year | If Under 24 Hrs. 6 Sex Age (In yrs. last birthday) 1 M 2 F Months Days Hours Usual Residence of Decedent 10d. Inside City Limits 10b. Count 10c. City, Town or Location 1 Yes 2 □ No It MORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21324 Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No Race - American Indian. Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Tyes 2 TWo Yes, Give ear or Dates: 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NQT use retired)

22. Name and Address of Facility Bradley

11/000

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ectopic pregnancy

5 Other (specify)

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or a spiratory of

Pheumonia

ue to (or as a consequence of):

Non small cell

Due to (or as a consequence of)

Due to (or as a consequence of)

yes, outcome of pregnancy

Pregnant at time of death

2 Fetal death

Live birth

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

18. Mother's Name (First, Middle, Maiden Surname

ON

24a. Was an

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence

autopsy performed? Yes 2 \to No

28d. Describe how injury occurred

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f shov

rai", or items 23a or 28a-f sho Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event. the Madical Eventine.

Baltimore, Maryland 21215-0036

Funeral Director

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Completed

Be

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Examiner

11. Marital Status

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical

2 No

5 Pending investigation

6 Could not be

determined

examiner?

27. Manner of Death 1 Natural

2 Accident 3 Suicide

4 Homicide

(check only

IF FEMALE:

(Specify only highest grade completed)

SON

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

shock, or heart failure. List only one cause on each line.

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

College (1-4 or 5+)

Physician/Medical

ģ

Completed

Be

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Certification:

Medical

or Attending Physician: The law requires that the death certificate be executed hysician and the burial-trans Division of Vital Records, P.O. Box 68760, been signed by the a should be detached after death.

Director: After this certificate filled in by the funeral e Funeral the Hospital within 2 To the I

> State Registrar

Lana Elpert 31. Date filed (Month, Day, Year) 7 2011 HIN 2

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number LES -000

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

23d. Date of delivery

Month

23e. Did tobacco use contribute to the cause of death?

2 □ No

3 Probably

1 Tyes

6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

2 □ No

-uneral Home

Approximate Interval Between Onset and Death

4 Unknown

5 days

2011

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28c. Injury at Work?

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20339 State of Maryland / Department of Health and Mental Hygien (UT) Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 6/24/2011 Physician/ 8:20 P M Patty M. Bollinger Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Hanover 7548 Old Telegraph Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country) 1 ☐ M 2🛣 F Days Hours Month 20ay Year) 19 VA Yrs 92 **Director** 226-16-4165 Usual Residence of Decedent 10d. Inside City Limits "natural", or items 23a or 28a-f show sdical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 No Hanover MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21076 7548 Old Telegraph Rd, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. Yes 2 No 1 Never Married 2 Married δ 1 Yes 2 No Specify: Specify: White If Yes. Give 3XXWidowed 4 ☐ Divorced Completed Year or Dates Medical 16a Decedent's Usual Occupation 16h Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) the Her Home Homemaker of Health and Mental Hygi item 27 is marked other other traumatic event, it Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Eleanor Pritchett Frank Sterling Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8130 Cloverhurst Rd., Glen Burnie, MD 21061 <u>Sylvester J. Bollinger/Son</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Department of Important: If any injury or once. 6/28/2011 Sykesville, MD Lake View Mem. Park onation 5 Other (Specify) 21. Sigr of Funeral Service Licenses ²² Name and Address of Facility Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause pri each line. Approximate Interval Between et and Death Immediate Gause (Final menla Physician/ disease of condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery Month Year Day 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 1 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 26. Place of Death (Check only one) 25. Was case referred to medical completed filled in by the funeral director, Other: 2 No 4 Nursing Home 5 Residence 6 othe 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

State Registrar

Medical

only one)

30. Name and address

31. Date filed (Month,

29b. Signature and title of certifier

of person who completed cause

filed within 72 hours after

and 2 should be

. Page 1

Hospital or Attending Physician: The law requires that the death certificate be

Box 68760

P.O.

Division of Vital Records,

Maryland 21215-0036

Baltimore,

Decritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edward Theodore Breuer Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Meritus Medical Center Hagerstown 8. Date of Birth June 26, 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, Social Security Number **Funeral** Year 19<u>12</u> Months Hours California 1 🗆 M 2 🗀 98 Director 558-03-8027 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a, State 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No Smithburg MD Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21783 4117 Garfield Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes Give "natural", 3 ♥ Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) chemical supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mabel Delores Klug William John Breuer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4117 Garfield Rd; Smithburg, Maryland 21783 James Breuer - son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Sign re 1 uneral S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ouse (Final disease or condition resulting in death) TRANSIENT JSCHEMIC Ph, sician/ Medical Due to (or as a consequence of) Examiner PERTENS Sequentially list conditions, due to for as a consequence of: Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury DENZMZIA To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician as the burial-Physician/Medical P.O. Box 68760 attending use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Day Year in the past 12 months? for Pregnant at time of death 2 No 9 Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has performed 1 Yes 2 No this certificate 1 Yes 2. No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No 1 🔄 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 T Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after death To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MOHAMMPO) Ldo892 A212 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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Vand a Jaye Bow	1	- For State	State	of Maryland		ment of <i>icate of</i>		nd Menta		Reg. No.	2011	20341
Physiciai Medical Examin	1/	I. Decedent's Name					· ·		2. Date of De Month June 1, 2	Day	Year	3. Time of Death 1830 hrs
VICUICAI EXAMINI		Wanda J la. Facility Name (i	Taye Bowe f not institution, gi	ve street and number	.)	4	b. City, Town, o			4c. 0	County of Death	
	4	Meritus Med		17 A	ge (In yrs. last I	hirthday)	Hagerstow		24Hrs. 8. Date of B		ashington	thplace (State or UNK
Funeral Director		5. Social Security N	1	M 2 X F		3 Yrs.	Months Day		Min. Oct 12		Foreig	gn untry)
Au a	-	Jsuat Residence of 10a. State	10b. County		10c. City, To	wn or Locati	on	<u> </u>				10d. Inside City Limits
land f show	٦	MD		ington	На	agerst				40= Citi	n of Milhad Carr	1 Yes 2 No
ith the Maryland 23a or 28a-f sho	ě		Church S				10f. Zip Code 2174			U	n of What Cou SA	
ITHOOFE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nem of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Marrie		12. Was Deceder d Armed Forces 1 Yes d If Yes, Give Year		If Ye	s Decedent of Hilles, specify Cuba	n, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)		4. Race - Amer White, etc. pecify: Whi	ican Indian, Black,
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136 thin 72 hours te. than "natur edical Exam	Completed	Elementary/Seco	ondary (0-12)	College (1-4 o	r 5+)	during me	ost of working life	e. DO NOT u	se retirea)			
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21215-0036 Jud be filed within 7 Mental Hygiene. marked other than ic event, the Medites	Be	.,,,,	(,	, allie								
and 2 should feath and Me tem 27 is man traumatic ev	<u>٩</u>	19a. Informant's Na		Type, Print)		900	W. Balt	imore	St; Balti	more,	MD 212	201
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Baltil permit. J Departm Importa	ı	21. Sign - Fi	neral Ser ce Lice	Di Di	rector	1 6	555 W. B	Baltimo	State Ana ore St; Ba	1timo	ore, MD	21201
Physician /Medical	4	23a. Part I. Enter the failure. List on Immediate Cause (ly one cause on	nplications that cause each line. a. Salmonel:		not enter th	ne mode of dying	g, such as ca	rdiac or respiratory a	rrest, shock	k, or heart	Approximate Interval Between Onset and Death
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O, be executed rsician and burial - transit	edical	X UNPENDED		AMENDED 23	a,pt.II	,27,pe	er me,g9	17 7-2	5-11 sm			
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	ŚΙ	IF FEMALE: 23b. Was decedent past 12 month:	s?	-	ome of pregnar	2 Fe	tal death 3	Ectopic	pregnancy		Date of deliver Month	y Day Year
D. B.		/ C		contributing to de	ath but not resu	ılting in the u	inderlying cause	given in Par	t 1. 23e. Did	tobacco us	se contribute to	the cause of death?
P. P. Cres that signed be det	ğ	Drug a	nd Alcoh	ol use _		_						bably 4 Unknown
tal Records cian: The law requi certificate has been ector, page 2 should	Completed								per	is an opsy formed? s 2 No		utopsy findings available completion of cause of
II Re	္မွ	25. Was case refer	rred to medical				26.Pla	ce of Death (Check only one)	, 2 110		
Vita hysicia this ce	To Be	examiner?	2 No			R/Outpatient			Nursing Home 5	Residen		er:
n of Iding Pl h. : After e funeral	<u></u>	27. Manner of Dea 1 Natural	th 5 Pending	28a. Date of li (Month, Day		8b. Time of I	· · _	ijury at Work?] Yes 2		e now injur	y occurred	
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should	Certification:	2 Accident 3 Suicide	Investiga 6 Could no determine	ation 28e. Place of	Injury - At hom	e, farm, stre	et, factory, office	building, etc	28f. Location or Town		d Number or R	ural Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical Ce	4 Homicide 29a. Certifier (Check only one) 2 ✓		ician: To the best of er:On the basis of e	xamination and	death occu	rred at the time, tion, in my opinio	date and place on, death occ	ce, and due to the ca curred at the time, da	use(s) and te and plac	manner as sta	ted. he cause(s)
To vitil To con	Mec	29b. Signature and	ditile of Carliff	and manner state	Apr	04	1	nse number				onth, Day, Year)
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		30. Name and add Victor Wee		o completed cause of Assistant Medic			V. Baltimore	Street, Ba	altimore, MD 21	223		
St	ate	31. Date filed (Mor			trar's Signature							
Regist	rar	JUI	y 2 7 201	1 Serve	1	parks						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 [] State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		ificate of Death	, ,	Reg. N	0.			
Physici		Decedent's Name (First, Middle,Las	2.	Date of Death Month Day	Year	3. Time of Death				
Medical Exam	iner	Donald Leroy Be 4a. Facility Name (if not institution, give	nnett			J∪ne 4, 2011		2244 hrs		
		St. Joseph Medical Center	•	4b. City, Town, or Loc Towson	cation of Death	ľ	4c. County of Death Baltimore Cou	ntv		
Funeral	_	5. Social Security Numberunk 6. Se			If Under 24Hrs.	8. Date of Birth/M		nplace (State or Unk		
Director			м 2 <u></u> F 64	Months Days		Feb 16,	10/7 Foreign			
		Usual Residence of Decedent	M 2 P 0 T	Yrs.		100 10,	2317 Coc	ritry)		
any		10a. State 10b. Countyunk	10c. City, T	own or Location unk				10d. Inside City Limits		
. ₫	_	MD					1	nk 1 Yes 2 No		
Maryland 28a-f shuw 1 at once.	cto	10e. Street and Number unk		10f. Zip Code UI	nk	10a, C	itizen of What Coun			
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eath with the Maryland items 23a nr 28a-f shn ust be notified at once.	<u>ia</u>	11. Marital Status UNK	12. Was Decedent Ever in U.S.	. 13. Was Decedent of Hispan	nic Origin? (Spec		14. Race - Americ	an Indian Black		
leath r item	Funer	1 Never Married 2 Married	Armed Forces?UNK	If Yes, specify Cuban, Me			White, etc.	an in anal, Diagra,		
after all", o	by F	3 Widowed 4 Divorced	If Yes, Give Yeer	1 Yes 2 No s₄	pecify:		Specify: Wh	ite		
ours a		15. Decedent's Education (Specify on	ly highest grade completed)	6a. Decedent's Usual Occupation			. Kind of Business/Ir	dustryUNK		
5-0036 led within 72 h Hygiene. other than "n	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working life. DC	NOT use retired)				
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	ä	19a. Informant's Name/Relationship (T	mo Print \	405 Mailine Address 10						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens. Important: If item 77 is marked other than "natural", or items 23a nr 28a-faha injury or nither traumatic event, the Medical Examiner must be notified at once	욘	O.C.M.E.	pe, i mit)	19b. Mailing Address (Street an 900 W. Baltin						
and 3		20a. Method of Disposition	20b. Pla	ace of Disposition (Name of cemete	-		Location - City or 1			
Baltimore, bermit. Pages I at Department of He important: If ite		1 Burial 2 Cremation 3	Removal from State cre	ematory or other place)			•			
Iting iit. Partament your		4 Donation 5 Other Specify:	00 1/1	22 Name and Address of E	Facility a					
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Physician	1	23a. Part I. Enter the disease, or compl	nore, MD	Approximate Interval						
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Box 687 death certifu he attending d for use as t	흥	past 12 months?	4 Pregnant at time of death		Ectopic pregnancy	·	Month Da	ay Year		
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ires that the signed by the detache		Part II. Other significant conditions	contributing to death but not resu	ulting in the underlying cause given	in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?		
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on of Vital Records, sading Physician: The law requirement of the control of the	To Be	examiner? 1 ✓ Yes 2 No	ospital: 1 🗸 Inpatient 2 🔲 El		er ₄ Nursing H		ence 6 Other:			
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Division pital or Attendii ours after death, oeral Director: /	iji	3 Suicide 6 Could not b	200 Dinne of Injune At hom	e, farm, street, factory, office building	ing, etc. 28f		and Number or Rura	Route Number, City		
E G G E	Certification:	4 Homicide determined	(Specify)			or Town, State)				
9 2 9 9		29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:	n: To the best of my knowledge,	death occurred at the time, date as	nd place, and due	to the cause(s) a	nd manner as stated	1.		
To th withi To th	Medical	29b. Signature and title of certifier	and manner stated.	/or investigation, in my opinion, dea						
		A AAS	/ /	29c. License nu			Date signed (Mont	n, Day, Year)		
		family out	all (MI)	O.C.M.E		Jui	ne 5, 2011			
		30. Name and address of person who ca Pamela E. Southall, MD		^{Ba)} iner 900 W. Baltimore St	treet Raltima	re MD 21222				
St	ate	31. Date filed (Month, Day, Year)	62. Registrar's Signature	A DARWING OF						
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Patricia Louise Combs Medical 2011 June а 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Oct. 19, Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 1 🗆 M 2 😾 F Hours Director 216-28-1909 80 WV Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Tes 2 No MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21234 U.S.A 8202 Bon Air Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: "natural" 3 😾 Widowed 4 🗌 Divorced Completed White 2 should be filed within 72 hours th and Mental Hygiene. 27 is marked other than "natura traumatic event, the Medical E. Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 11 years Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Josephine Preston Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Parkville, MD 21234 (daughter) 8202 Bon Air Rd Brenda Hirsch 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Carroll Cremation, Inc 6/27/2011 Hampstead, MD 22. Name and Address of Facility Eline Funeral Home Signature of Eureral Service Licenses 21136 Reisterstown Rd. Reisterstown MD Part 1. Enter the disease, or complication, that cau shock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last attending physiciar Physician/Medical Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death for in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day the 9 Unknown Unknown P.O. signed by Other significant conditions contributing to death but not resulting in the underlying rause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by etis Records, 1 Tes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy performe death? 1 Yes funeral director, 25. Was case referred to medical of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 1 No ည 1 Yes becco 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work? Division 1 Yes 2 🗌 No Accident Investigation filled in by the Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 81 30. Name and address of person who completed cause of death (Item 234) (Type Print) Bino 10 State Date filed (Month, Day, Year, 32. Registrar's Signature IIIN 2 7 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G916 6/27/2011 IH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> Physician/ 1:40 A M Evan Thomas Casey 19, June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1303 North Avenue Arbutus 5. Social Security Number Age (In vrs. last birthday, 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Ye Year) 2002 1 □**X**M 2 □ F Months Days Hours 216-65-8934 8 **Director** Maryland Usual Residence of Decedent or 28a-f show 10a. State 10b. County an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Arbutus 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1303 North Avenue 21227 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced White Specify: Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Shawn Thomas Casey, Sr. Stacy Ann Platt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Stacy Ann Casey - Mother 1303 North AVenue, Arbutus, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Buna 2 Cremation 3 Removal from State Woodlawn Cemetery ☐ Donation 5 ☐ Other (Specify) 6-24-2011 Woodlawn, MD Funeral Se /22. Name and Address of Facility Amnrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Encephalopathy Onset and Death disease or condition Medical resulting in death) Due to (or as a consequen Examiner Seizure Byr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown ed by the a P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes this certificate has but director, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 2 N 1 🗌 Yes of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 The sidence 6 Other (Specify) HOSTICS 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending Division hours after death. uneral Director: After and filled in by the fun 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or A within 24 hours after To the Funeral Direct completed filled in b Medical 29a. Certifier 1 👿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi 29c. License numbe 29d. Date signed (Month, Day, Year) 071070 June 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Welf MD 200 N Woife St, Ste 2158 Baltimore, MD 21287 32. Region State Registrar

11-04665 Tiwiah Karlay Cole

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month 2117 hrs June 21, 2011 **Medical Examiner** Cole Tiwiah Kalay c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or Months | Days | Hours | Min. | According 1961 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Aug 28 1961 Country) Leone Director 214-41-9439 1 X M 2 F 49 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State iny 1 X Yes 2 No Riverdale s 23a or 28a-f show e notified at once. MD Prince George's hours after death with the Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20737 6353 64th Ave #D6 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Funera White, etc. Never Married 2 Married Armed Forces? Yes Black 1 Yes 2 X No specify: Specify: If Yes, Give Year 3 Widowed 4 Divorced Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after
Department of Health and Mental Hygene.
Diportant: If item 27 is marked other than "matural",
injury or other traumatic event, the Medical Examiner. ≥ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 5+Teacher Private 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Phibian Thomas Be Alfred Cole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6353 64th Avenue, #D6, Riverdale, MD 20737 Zainab Turay/ Wife 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 07/09/2011 Silver Spring Gate Of Heaven Ceme. 4 Donation 5 Other Specify: 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road, Landover, Maryland 20785 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Medical Death a. Hypertensive Atherosclerotic Cardiovasular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and sician/Medical AMENDED 23a, pt. II, 27 per me g916 6-28-11 sm X UNPENDED ned by the attending physician a detached for use as the burial -Records, P.O. Box 68760, The law requires that the death certificate be experienced. 23d. Date of delivery 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions signed by i Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown <u>چ</u> Electrolyte imbalance; Diabetes Mellitus Completed 24a. Was an 24b. Were autopsy findings available certificate has been ector, page 2 should prior to completion of cause of autopsy performed? death? Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical funeral director. Division of Vital examiner? Other Nursing Home 5 Residence 6 Other: this 1 🗸 Yes 2 No 28c. Injury at Work? After 1 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 X Natural 1 Yes 2 No 5 Pending death. the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by 3 Could not be Suicide determined 24 hours a Homicide To the Hosp within 24 ho To the Func completely f 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day Year) 29c. License number 29b. Signature and title of certifier June 22, 2011 O.C.M.E. 10 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD

Registrar

JUN 2 7 ZOTY

ar's Signature

11-03799 Samuel A. Clark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 20346

		1- For State Certificate of L		Reg.	No.	
Physici	an/	Decedent's Name (First, Middle,Last)	ay Year	3. Time of Death		
edical Exami	ner	Samuel A. Clark		Month D May 20, 201	1	1605 hrs
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Funeral Director		1X M 2□F 60 Yrs.	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	Jan 19,	TOF1 Foreig	
<u> </u>		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1			10d. Inside City Limits
Maryland 28a-f show any <u>d at once</u> .	_	MD Baltimore				1 Yes 2 No
arylan Sa-fs	용		Of. Zip Code	10g.	Citizen of What Cou	ntry?
the Ma 3a or 2	Director	5021 Pennington Avenue; Apt 8	21226		USA	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland art of Healand Mental Hygiene. Inti If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral		Decedent of Hispanic Origin? (Sp., specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	ican Indian, Black,
after al", o	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Y	es 2 X No specify:		Specify: blac	
ours Astur	p	during most	Usual Occupation (Give kind of w t of working life, DO NOT use retir		6b. Kind of Business/	Industryunk
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215-0036 be filed within 7 ntal Hygiene.	Be C	17. Father's Name (First, Middle, Last) unk		(*,,	dir	X.
D 21215-0036 should be filed within 72 hours after and Mental Hygiene. 7 is marked other than "natural", antic event, the Medical Examiner.	To E	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	ddress (Street and Number or R	ural Route Numbe	er, City or Town, State	e, Zip Code)
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ore, MC so I and 2 so of Health ar If item 27 her traum?		20a. Method of Disposition 20b. Place of Disposition		Date 2	20c. Location - City or	Town, State
Pages ment of tant: I		1 Burial 2 Cremation 3 Removal from State crematory or other 4 Donation 5 Aprher Specify: 11 State				
Baltimore, MI permit. Pages 1 and 2 s Department of Health a: Important: If item 27 injury or other traum		21. Signature of Funeral Service Licenses 22. Name	ne and Address of Facility Sta	te Anato	my Board	
CO SOLE		Sm/1/100 65	55 W. Baltimore	St: Balt	imore, MD	
Physician /Medical	Ĭ	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. ATHEROSCLEROTI	C CARDIOVASCULAI	respiratory arrest R DISEAS	, shock, or heart E	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease a. COMPLICATED B	Y COCAINE USE			Death
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O. In at the d by the stacker		Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.		cco use contribute to	
F, P.C ires that signed l	d by	PROBABLE GASTROINTESTINAL HEMORRHAG	E	1 Yes	2 No 3 Prol	bably 4 Unknown
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tal Rec		25. Was case referred to medical	26.Place of Death (Check of			
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nursing	g Home 5 Re	esidence 6 🗸 Othe	r: Scene
ling Ph After t funeral		27. Manner of Death 28a. Date of Injury 28b. Time of Injury	ry 28c. Injury at Work?	28d. Describe how	v injury occurred	
ion teath. tor:	랿	Natural 5 Pending (Month, Day, Year) Accident (Month, Day, Year)	1 Yes 2 No			
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safer death. al Director: After this certificate has been signed by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,	factory, office building, etc.	28f. Location (Stre or Town, Stat		ural Route Number, City
Daspital hours inceral		4 Homicide (Specify) 29a. Certifier 1 Certifying Physician: Vo the best of my knowledge death occurrence.		104 10 -045		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Foneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	one) 2 Medican Examiner: On the basis of examination and/or investigation				
F. × 5	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Mo	nth, Day, Year)
		' // // ~	O.C.M.E.		May 21, 2011	
OCME		30. Name and address of person who completed cause of death (Item 23a)				
		Mary G. Ripple MD. Députy Chief Medical Examiner 900 V	V. Baltimore Street, Baltin	nore, MD 212	23	
Si Regis	ate	31. Date filed (Month, Day, Year) 111N 2 7 2011 Leves 3. Sacks	/			
regis	JK: II	THE REPORT OF THE PARTY OF THE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 201 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country)
Lock Haven, 8. Date of Birth (Month, Day, Year) Aug 21, 1953 7. Age (In vrs. last birthdav) 5. Social Security Number **Funeral** 1 □ M 2 🛛 F Days Haven, Pa. 180-44-3263 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County show Pine Grove Mills 1X Yes 2 □ No PA. Centre Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō pe U.S.A. ral", or Items 23a Examiner must be P.O. Box 206, 16868 Butternut Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify. If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced "natural" 16b. Kind of Business/Industry
Penn State Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than "natur. ent, the Medical E 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) University 12th <u>Staff Assistant</u> marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (unk) Phoebe Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1686819a. Informant's Name/Relationship (Type. Print) P.O.Box 206, Butternut St., PineGroveMills, Pa. Edward L. Conklin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June Date permit. Pages 1
Department of IImportant: If ite
any Injury or ot
once. 1 ☐ Burial 2√ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MoriartyF.H.&Crem: 24,2011 Lock Haven, Pa. 22. Name and Address of Facility Moriarty Funeral Home Crem. 21. Signature of Funeral Service License 112 E. Church Street Lock Haven, Pal7745 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Autoinmune Immediate Cause (Final Physician disease or condition resulting in death))/Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death Check onl one) Be examiner? Other: 4 \square Nursing Home 1 ☐ Yes 2 ✓ No Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 5 Residence 6 Other (Specify) မ After this 28a. Date of Injury Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b Certification: (Month, Day Year) Injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29b. Signature and title of certifier D68872 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Mitchell

MD

Johns Hopkins Hospitz

32. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiers State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ James Keefe Donahue 00:10 AM 06 Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE, MD Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MA **Funeral** 8. Date of Birth 1 XM 2 M57297 1923 262-22-6934 Director 88 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Completed by Funeral Director 10d. Inside City Limits 1 Yes 2XXNo Lutherville Baltimore 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 7 Bluestone Rd. 21093 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married XXYes 2 No Maryland 21215-0036 If Yes, Give Year or Dates. 1943-55 1 ☐ Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) President & CEO Trade Show Producer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward Arthur Donahue Madeline Keefe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Donahue/Wife 7 Bluestone Rd., Lutherville, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 10/25/2011 Arlington, VA 21. Signature of Funeral Service Burrier-Queen Funeral Home & Crematory, P.A. ame 1212 W. Old Liberty Rd., Winfield, MD 21784 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTIC SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or inthat initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be MYOCARDIAL INFARCTION P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Yes 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, END STAGE RENAL DISEASE HYPERTENSION, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown DIABETES, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No မ Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury Accident Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number June 23 RES 000 M·D AKASAPU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARUMAKAR 0+1 BALTIMORE, MD-21239 BLYD, 5601 LOCHRAVEN 31. Date filed (Month, Day 32. Registrar's Sig State Registrar

Y DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ,07 Month 14NE Medical 4a. Facility Name (if not institution, give street and number) An Examiner 4b. City, Town, or Location of Death 4c. County of Death LOKTHWES 485DITHL JAANS CENN BALLIMENE Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year **Funeral** 8 Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Months Hours Min 1673 Pay 215-92-0735 1964 Maryland Director 46 Yrs Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State Director 10c. City. Town or Location 10d. Inside City Limits MD N/A 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 3413 Fairview Ave. Apt A4 U.S.A. 21216 and 2 should be filed within 72 hours after death Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 12th Grade College (1-4 or 5+) Disability is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Earl Cecil Day injury or other traumatic Dorothy Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health au
Important: If item 27 is Deborah Davis(sister) 4637 Park Heights Ave. Apt 1-12, Balto., MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State King Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 06/28/11 Baltimore, MD 21. Signature of Funeral Service Licenses Joseph H. Brown Jr Funeral Home PA 140 N. Fulton Ave., Baltimore, MD any 2140 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital. 2 1100 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title o 29c. License number 502 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mont State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20350

		1- For State		Ce	rtificate d	of Death			R	eg. No.		
Physici		Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Name (First, Middle, Last)										
edical Exami		Debra Lynn	Denice						June 21,	2011		1220 hrs
		4a. Facility Name (if not instit		d number)		4b. City, Town		of Death			ty of Death	1
		434 Kinslow Street				Hagersto				Wash		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 \					YY) 9. Bir Co	rthplace (State or Foreign
Director		216-76-4403	1 M 2 X	_F 55	Υ	Months [ays Hours	Min.	3/22/	1956		D.C.
	ŀ	Usual Residence of Deceden										
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P wo	ᆡ	MD Was	shington	Н	agerst	own						1 Yes 2 X No
Maryland 28a-f show any d at once,	윙	10e. Street and Number				10f. Zip Cod	9			l 0g. Citizen of	What Cou	intry?
th the Maryland 23a or 28a-f sho notified at once.	Director	/0/ 77: 1	0.5			21	740				USA	
ith th	l i	434 Kinslov		Decedent Ever in U	IS 13 V	Vas Decedent of		gin? (Spe	cify Yes or No			rican Indian, Black,
ath w	Funeral	1 Never Married 2 X	Married Arme	ed Forces?		Yes, specify Cu				W	hite, etc.	
er de:		3 Widowed 4	Divorced If Yes, Give		1	Yes 2X	No specify:			Specia	fy: W	hite
rs aft. ural" mine	þ	15. Decedent's Education (or Dates:			ent's Usual Occi			ork done	16b. Kind of		
D 21215-0036 should be liked within 72 hours after death with the Maryland and Monda B Hygien 72 hours after death with the Maryland is marked other than "natural", or items 23a or 28a-f shot ratic event, the Medical Ex miner must be notified at once.	Completed	Elementary/Secondary (0-		ge (1-4 or 5+)		most of working						
36 un 72 than diezl	ble		12)	J C (н	omemake	r			Her	Hom	e
-00 with giene	uo.	12 17. Father's Name (First, Mic	idle, Last)			Omemare		r's Name (First, Middle,	Maiden Surna		
215-0036 be filed within 7 ntal Hygiene. rked other than	Be C	Jesse Robe		ton			El	len 1	Lowry			
21215-0036 und be filed within 77 Mental Hygiene. marked other than ic event, the Medical	o B	19a. Informant's Name/Relati	ionship (Type, Print)	19b. Mail	ing Address (S	treet and Nu	mber or Ru	ural Route Nu	mber, City or 1	Fown, Stat	e, Zip Code)
	_	Joseph R. D			434	Kinslo	w St	Hage	erstow	n, MD 2	21740	
		20a. Method of Disposition	chiec, nas	20b.	Place of Disp	osition (Name o			Date			r Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If iten njury or other tr		1 Burial 2 X Crema	ation 3 Remov	/al from State	crematory or			6.10	/ /0011	773 4	::-11	MD
Lim Pag ment tant		4 Ronation 5 Othe		S.		11 Crem					ield	
Sal ermi bepar mpo njury		21. Signature of Funeral Services	rema	tory, P.A.								
		23a. Part I. Enter the disease	heart	MD 21784 Approximate Interval								
Physician Medical		fallure. List only one ca		Between Onset and Death								
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		Condition resulting in deal		as a consequence	OT):							
	J.	Sequentially list conditions, if any loading to immediate	b. Due to (or	as a consequence	of):						-	
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r is	Examiner	events resulting in death) La		as a consequence	of):							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the fineral director, page 2 should be detached for use as the burial - transit			d					_			_	
760, cate be ex physician he burial	Medical	UNPENDED	AMEND	DED								1
760, icate be physical the buri	₹	IF FEMALE: 23b. Was decedent pregnant	in the	yes, outcome of pre		F	2 Eston	io prognar	201	23d. Dat Mont	e of delive	pry Day Year
Box 68: e death certifi the attending ed for use as	sician/	past 12 months?	1 '	ive birth Pregnant at time of d		Fetal death Other (Specify)	3 Ectop	ic pregnar	icy	1		Day
SOX leath e atte for u	ysic	1 Yes 2 No 9 🗸	Unknown	Jnknown	3	Other (opeany)						
D. Be t the de by the	Phys	Part II. Other significant co	nditions contribut	ing to death but not	resulting in th	e underlying ca	ise given in F	Part I.				o the cause of death?
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ords, w require is been si should b	ted								24a. Wa		4b. Were a	autopsy findings evailable
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thysic Linis	2	1 ✓ Yes 2 No		Inpatient 2	ER/Outpati				g Home 5	Residence e how injury oc		ner; Scene
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Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyin	ng Physician: To th	e best of my knowle	edge, death o	curred at the tim	e, date and p	olace, and	due to the ca	use(s) and ma	inner as st	ated.
To the How within 24 h To the Fun completely	Medical	- 22.5		pasis of examination iner stated.	and/or invest				t the time, da			
	ž	29b. Signature and title of co	ertifier /				cense numbe	er			-	flonth, Day, Year)
	1	(and	HELL	Our	-		.C.M.E.			June 22	2, 2011	
		30. Name end address of pe										
		Carol Allan, MD	Assistant Med	ical Examiner	900 W. E	Baltimpre Str	eet, Baltin	nore, M	D 21223			
	state		(ear)	32. Registrar's Sign								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Year Month 50 cM > Medical Charles F .'S 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number . Age (In yrs. last birthday 8 Date of Birth **Funeral** 1 M 2 □ F Days (Month, Day, Yea 2 19 1944 220.42.8033 Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director Baltimore Randallstown MD 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral Advianne 21133 Court permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ontractor Home Improvement Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Charles D. Fisher, Sr. Made Maides 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 19a. Informant's Name/Relationship (Type, Print) Hoy Daughter Avenue LISA Hazelwood 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Windsor Mill, MD King Momorial 2011 Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility augin . Greene Funeral Service 8728L Road 7 Pandallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fa ure. List only one cause on each line Interval Between Immediate Cause Final Onset and Death Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Lu hnone Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) burial-transi moner and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Vear Pregnant at time of death signed by the a 1 L Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown After this certificate has been significate has been significated funeral director, page 2 should the 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No ပ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 129085 ed of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD Court 21153 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 31AM GARNER 201 FTHERINE JUNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY IA Komit WASHINGTON ADVENTIST HOSPITAL 9. Birthplace (State or Foreign Country) Nash County NC 7. Age (In yrs. last birthday) 78 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1932 (Month, Day, Year) **Funeral** 1 □ M 2🛣 F Hours Months 244-48**-**6909 Director November Nash Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified ** once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 □ No District of Columbia Washington 10g. Citizen of What Country? United States 10e. Street and Number 10f. Zip Code 20003 Funeral #103 900 5th Street SE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc þ 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed 3₺ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 10th+Nursing Asst Certification Service Industry/Admin Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Henry Douglas Cooper Sr Annie O. Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8355 Elm Rd., Millersville MD 21108 Maria Garner/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 23, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Mem Park Landover, Maryland 4 Donation 5 Other (Specify) 2011 22. Name and Address of FacilityRobert G Mason Funeral Home Inc 21. Signature of Funeral Service b Donald R.\Gra 1661 Good Hope Rd SE Washington DC 20020 Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, shock, or heart failure. Lis mplications that caused the death Approximate Onset and Death Immediate Cause (Final disease or condition DYANIED Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner THRIVE URE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine STAGE Cause (Disease or injury that initiated events resulting in death) Last EN O To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4x Unknown Division of Vital Records, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2x No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: 2 No 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation ☐ Accident ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 UNE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A1000, 7600 CARROW AVENUE, THEOMA PARK,

Registrar

State

WIREON

32. Re

aistrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JUNE GROSSHANDLER SAMUEL 8:40 P M 21 2011 Medical 4a. Facility Name (if not institution Facility Name (if not institution, give street and number)
GILCHRIST HOSPICE CARE Examiner 4b. City, Town, or Location of Death TOWSON 4c. County of Death BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Days Hours Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F 91 115-12-3603 0970571919 Director Usual Residence of Decedent 10a. State 10b. County ms 23a or 28a-f sho must be notified at Oc. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director BALTIMORE BALTIMORE MD 1 Yes 2 X No 10f. Zip Code 21209 10g. Citizen of What Country? USA 6527 COPPERFIELD ROAD by Funeral "natural", or items 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian Armed Forces?

1 X Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 10 Black White etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
SALESMAN Elementary/Seconday (0-12) College (1-4 or 5+) INSURANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GROSSHANDLER BENJAMIN 2 DORA ITZKOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 6527 COPPERFIELD ROAD, BALTIMORE, MD 21209 SYLVIA GROSSHANDLER/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BETH EL MEMORIAL PARK 06/24/2011 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice e 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph, sician disease or condition WECES resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events wichs udration the attending physician and hed for use as the burial-transit Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year sate has been signed by the page 2 should be detached 1 L Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by antery disease, recent placement of 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospita 2 **N**No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Dear 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After it completed filled in by the funera Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatury and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (IPV) 10 i State

Registrar

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-5 show any injury or other trainmatic event the Medical Evaminer must be notified at any injury or other trainmatic event the Medical Evaminer must be notified at Baltimore, Maryland 21215-0036 Physici Medi Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

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		For		State of M	aryland / I	Departme	ent of H	Health and	Mental Hy	giene		
		State Registrar				Certifica	ate of L	Death		Reg. No	201	20354
Physicia	n/	1. Decedent's Name	,	•					2. Date of De Month	ath Da	y Yea	3. Time of Death
Medic	al		Lorrai	ne Grube		1		1 1 1 1 D 1	May	20,		10:28 P M
Examin	er	, ,		ngton Medi	cal Cen		*	r Location of Deatl Surnie	n	40	. County of De	Arundel Co.
Funeral		5. Social Security Nu	umber 6. 9	Sex 7 Ac	e (In yrs. last birt	hday) If Un-	der 1 Year	If Under 24 Hrs.	8. Date of Bir	th ,	9. 1	Birthplace (State or Foreign
Director		212-34-1	693	□м2Х F	73	Yrs. Month	ns Days	Hours Min.	(Month, Da	7, Year)	937 1	Country) Maryland
how	ř	Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town	n or Location						10d. Inside City Limits
3a-f s	Director	MD	Anne Ar	undel Co.		Burnie	1					1 ☐ Yes 2 🔀 No
or 20		10e. Street and Num			3		Zip Code			10g. Ci	tizen of What	Country?
is 23a nust b	Funeral	843 Ben	twillow :	Drive			2	1061			United	States
r item iner n		11. Marital Status	₩	12. Was Decedent Armed Forces?		13. Was Dec If Yes, sp	cedent of Hi becify Cuba	ispanic Origin? (Sp an, Mexican, Puert	oecify Yes or No- o Rican, etc.)		14. Race - Ai Black, W	merican Indian, hite. etc.
al", o	d by	1 ☐ Never Marri	ed 2 🕅 Married	1 Yes 2 X If Yes, Give Year or Dates.	. No	1 🗆 Yes	2 🗓 No	Specify:			0	hite
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e. han "ı	duc	Elementary/Seco		rade completed) College (1-4 or :	5+)	(Give kind of v		during most of wor	rking			
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red of	To B	17. Father's Name (F John Wi		achman				18. Mother's Na Elsie	me (First, Middle, Be11	Maiden Fuge		
mark matic		19a. Informant's Na			195	Mailing Addr	ass (Street	and Number or Ru	•			Zin Codel
althar 27 is rtrau				ube / Husb	_			ow Drive			ie, MD	
of Hei		20a. Method of Disp			20b. Place o	f Disposition (*)	lame of		Date			or Town, State
ant: If			☐ Cremation 3 L 5 ☐ Other (Spec	Removal from State					7/2011	Gle	n Burn	ie, Maryland
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fur	neral Service Lisen	See /		22. Name	and Addres	ss of Facility Si	ngleton	Fun	eral &	Cremation
		115	2000	7/-	M0112	1502.2					en Bur	nie, MD 21061
		shock, or hear Immediate Cause (F	t failure.List only	plications that cause one cause on each lin	the death. Do r	1/	1_ /	in		rest,		Approximate Interval Between Onset and Death
ysician/ Medical		disease or condition resulting in death)		a. Due to (or as	a consequence	Heu	MI	11stest		^		loyear
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cian a		resulting in death) L	Last	Due to (or as	a consequence	of):		J.	N APPROVED BY N	EDIC		
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nding Ise as	n/M	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome							23d. Date of	delivery
atter d for u	icia	in the past 12 n	nonths?	4 Pregnant a	2 Fetal death at time of death	n 3 ∐ Ectop 5 ☐ Other		су			Month	Day Year
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certificate has been rector, page 2 should		25. Was case referre	ed to medical	1			00 DI	() () ()	1 🗌 Yes			Yes 2 No
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eath. or: Aff he fur	fica	1 Natural 2 Accident 3 Suicide	5 Pending Investigatio	n 5/11/		boun M	work 1 \square	Yes 2 No	Fell	coh	le gr	o dening
fter d irect n by t	Certificate:	4 Homicide	6 ☐ Could not to determined			_	ory, office	·	28f. Location (\$ 843 ^{ity} Ben			Rural Route Number,
eral D		29a. Certifier 1	Ortificing Phy	vsician: To the best of		rden	at the time	data and place	Glen Bu	rnie	Mary Mary	rland
Within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical	(Check 2	Medical Exam		xamination and/o	or investigation,	in my opinio	on, death occurred	at the time, date	and place	e, and due to t	he cause(s) and manner stated.
rithir To the comp		29b. Signature and		Do a			29c. License	e number			-	onth, Day, Year)
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		Elliott 31. Date filed (Month	Gorbaty	, M.D. 1	411 Mad	ison Pa	ark Dr	cive, Sui	te 2B	G1e	n Burn	ie, MD 21061
Stat Registra		o i. Date filed (MOIRI	JUN 27	2011 32. 1801811	ar's Signature	gark						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 UDREY Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Annapolis Center If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Dav. Year. Months Days Hours Min. 74 **Director** 213-40-9997 Maryland 3-7-37 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified Chesapeake Beach 1 X Yes 2 No MD. Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Examiner must be Funeral 23a U.S.A. Breezy Point Road 20732 items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc þ 1 Never Married 2X Married "natural", or Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates er than "natur the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Homemaker marked other t 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Milford Jefferson Ollie Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and tem 27 is n Lemuel J. Harrod/Husband 2050 Peace Court, St. Leonard, Md. 20685 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/30/11 Heritage Memorial Waldorf, Md. 22. Name and Address of Facility
Hackett's Funeral Chapel,
814- Upshur Street, NW 21. Signi 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final set and Death Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or linjury Examine Due to (or as a consequence of) use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy atter fo Day 5 Other (specify) Pregnant at time of death 4 Pregnant
9 Unknown Yes 2 No neral Director; After this certificate has been signed by the filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ဂ 1.☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1-Natural injury 5 Pending 2 Accident Investigation 24 hours after deat Funeral Director; 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the မ D21438

• 15h

30. Name and address of berson who completed dayse of death (Item 23a) (Type, Print)

MICHAEL

J. La F.N.A. MD 14 P.F.E.N.F. Hwy ANNAPULIS MO 2440 (Item 23a)

State

31. Date filed (Month Day, Year)

32. Date filed (Month Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Hir schmann 2011 6:30pm M Elsie June 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Long View Nursing Home Carroll Manchester If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday **Funeral** 1 🗆 M 2 🗓 F Months Days Hours Director 214-24-4809 87 12-15-1923 MD Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ? is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MD Carrol1 Union Bridge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4344 Bark Hill Road 21791 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates 1 □Yes 2X No Specify. Ş Specify: White 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 years Own Home Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Ogden Gladys Fletcher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles R. Hirschman, III (son) 4344 Bark Hill Rd. Union Bridge, MD 21791 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 6-24-2011 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn Park, MD 22. Name and Address of Facility ELINE FUNERAL HOME 21. Signature of Funeral Service Licensee 11824 Reisterstown Rd. Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** 18aus disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) death certificate be executed and Due to (or as a consequence of) burial Box 68760. physician Physician/Medical the SB attending nse s IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 No P.0. 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
Yes 2 No has page 2 certificate 2 No Division of Vital 1 ☐ Yes 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 Mo 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending within 24 hours after deam.

To the Funeral Director: After the funeral properties of the funera 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and September 2011

31. Date filed (Month, Day, Year) ZpeV MD 2835 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

37573

June 22, 2011

21209

11-03994 Robert Holt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

Kobert Holt		State 1- For State Registrar	e of Maryland i		tment of ificate of i		d Mental I		eg. No. 20	sele-ru-ras	20357
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,La	ith Day Ye	ar	3. Time of Death 1748 hrs						
Miculcal Exami	ici	Robert Holt 4a. Facility Name (if not institution, g	ive street and number)		41	. City, Town, or	Location of Dea	May 28, 2	4c. County	of Death	
		4011 Penhurst Avenue				Baltimore	_				
Funeral Director			Sex 7. Age	e (In yrs. las 47	t birthday) Yrs.	If Under 1 Year Months Day			1, 1963	Foreig	hplace (State orunk n untry)
any	ł	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Location	1					10d. Inside City Limits
. ≸	5	MD		Bal	timore						1 X Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	10e. Street and Number 4011 Penhurst	Ave			10f. Zip Code 21215		1	0g. Citizen of W USA	hat Coun	itry?
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-fahr traumatte event, the Medical Examiner must be notified at once	Funeral	11. Marital Status UNK 1 Never Married 2 Marrie 3 Widowed 4 Divorce		Ever in U.S. UNK No	if Yes		n, Mexican, Puer	Specify Yes or No to Rican, etc.)	Whit	e, etc.	can Indian, Black,
ours aft stural"	d b	15. Decedent's Education (Specify	or Dates:	pleted) 1	6a. Decedent's	Usual Occupat	tion (Give kind o	f work done un		whi usiness/Ir	
5-0036 led within 72 hours al Hygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12) unk	College (1-4 or 5 unk	i+)	during mos	t of working life	. DO NOT use re	etired)			
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatte event, the Medica	Be Co	17. Father's Name (First, Middle, Las	unk unk				18. Mother's Nan	ne (First, Middle, I	Maiden Surname) unk	
2121 ould be fi d Mental]	밁	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing A	ddress (Stree	et and Number or	Rural Route Nur	nber, City or Tow	n, State,	Zip Code)
MD and 2 show alth and m 27 is		O.C.M.E.		16				; Baltin			
Baltimore, MD permit. Pages I and 2 st Department of Health an Important: If item 27 in injury or other trauma		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 X Other Specif		1	matory or othe			Date	20c. Location	·	Town, State
Balt permit. Depart Impor		21. Signal e of F era Servi	omy Boar ltimore,		21201						
Physician	0	23a. Fart I. Enter the direase, or com	applications that caused	the death. D							Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease			Death						
		or condition resulting in death) Sequentially list conditions,	Due to (or as a conse	quence of):							
	fedical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conse								
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50, te be executed yysician and burial - transit	dica	X UNPENDED	AMENDED 23a	27,28	a-f per	me g91	6 6-28-1	.1 sm			
c 687(certifica ending ph use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth 4 Pregnant at		2 Fetal	death 3 [Ectopic pregr	nancy	23d. Date of Month		ay Year
BOy he death y the att	hys	1 Yes 2 No 9 Unknow Part II. Other significant conditions	9 Unknown	h		(anh dan a a a a a	i i- B1	Day Did to		danka ta t	he cause of death?
Records, P.O. I The law requires that the cate has been signed by the page 2 should be detached.	Completed by I	Tartii. Ottor eigimeant conditions	contributing to death	but not resc	alang in the and	errying cause g	iventii Faiti.			_	ably 4 Unknown
of Vital Records, ag Physician: The law requirement. The true requirements certificate has been a meral director, page 2 should be	E E							24a. Was autop	sy p	orior to co	opsy findings available ompletion of cause of
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n of Vi	읽	1 Yes 2 No 27. Manner of Death	28a. Date of Injur (Month, Day,Ye	y 2	Bb. Time of Inju		y at Work?		now injury occur		Scerie
~ # . ^ æ	턃	1 Natural 5 Pending 2 Accident Investiga	fd 5-28-		d 5:40	pm 1 T	es 2 No	Unknown			
Division Hospital or Attendir 24 hours after death. Funeral Director: A	Certification:	3 Suicide 6 X Could no determine	and in its		e, farm, street, t home	factory, office b	uilding, etc.		tate)4011		al Route Number, City urst Ave.
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medicai (clan: To the best of my er:On the basis of exam and manner stated.								
	Ž	29b. Signature and title of certifier	000			29c. License			29d. Date sign		th, Day, Year)
		toti lla	- Koll	C	1-1	0.0.1	vi.⊑.	·	May 29, 20	HT	
		 Name and address of person who Patricia Aronica-Pollak M 				00 W. Baltin	nore Street,	Baltimore, MI	D 21223		
Sta		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1	,					
Regist	СШ	<u> </u>	Januar		Barker						

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day JUNE 19, BARNET 2011 R HOFFMAN 4:37 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death ARDEN COURTS BALTIMORE BALTIMORE Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) Days Months Hours **Director** 0472971918 136-18-7778 93 N.I Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No BALTIMORE BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1 POMONA EAST, UNIT 308 21208 USA 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married within 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give 3 X Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) DENTIST DENTISTRY d be filed with defined with a marked of Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SOLOMON HOFFMAN ROSE GERSTEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health aitem 27 i STEVEN HOFFMAN/SON 8528 PARK HEIGHTS AVENUE, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State ANSHE EMUNAH ATTZ CHAIM CEMETERY 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/22/2011 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mass Le 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Alzheimers) emen T19 disease or condition Kars Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical 68760 IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 months? 3 Ectopic pregnancy for Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached f 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Adunknown page 2 should een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Tes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) living Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowled as a state of my kn only one ted at the time, date and plans, and due to the 29b. Signature and title of certifier 29c. License number D0061199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 701 N Charles St, Svite 4105, Touson MD 21204 mo. Jason Black 31. Date filed (Morth, Day, Year) 32 . Pegistrar's Signature State Registrar

DHMH 17 Rev 7/2009

			For State Registrar	State of M	aryland / Depa	artment of H			giene	20359	
	Observation.		1. Decedent's Name (First, Middle, Las	2. Date of D Month			Death 3. Time of Death				
	Physici /Medic		Bernice Keefer Jones			June 2					
1	Examin		4a. Facility Name (If not institution, give	4b. City, Town, or	Location of Deat	h	4c. County of				
		Director	Carroll Lutheran Village			Westminster			Carroll		
re, Maryland 2	Funeral Director		219-42-6199	9x 7. Aq □M 2∏XF	ge (In yrs. last birthday) 99 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		v, Year)	Birthplace (State or Foreign Country)	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
	f sho		MD Carrol	1	Mostr	inster				1 ☐ Yes 2 🕅 No	
	1the 1286		10e. Street and Number	<u> </u>	Wesch	10f. Zip Code			10g. Citizen of Wh	at Country?	
	3a ol		200 St. Matthew	Court		21158			United S	States	
	after deat or items?	To Be Completed by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces' 1. Yes 2 ☐ If Yes, Give	No	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race Black,	American Indian, White, etc.	
	ural',		3X Widowed 4 □ Divorced	Year or Dates:						White	
	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural" or items 23a or 28e-1 show any injury or other treumatic event, Ite Madical Examiner mast be notified at once.		15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	kind of work done during most of working DO NOT use retired)				o. Kind of Business/Industry Health Care			
			17. Father's Name (First, Middle, Last)	2 years	∣ R€	gistered		mo (First Middle	Maiden Sumame		
			McClelland Kee	fer				N. Haine		,	
			19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a				tate, Zip Code)	
			Suzanne N. Selby	(niece)		dington F					
			20a. Method of Disposition 1 □ Burial 2X Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, cre			Date		ity or Town, State	
			* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Physics Lice.)	Carroll (Hampsto		
Ba				Wayne Os		2. Name and Addres .1824 Reis				vn, MD 21136	
.O. Box 68760,	Pnysician /Medical Examiner	ner	23a. Cart1. En of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final)								
			Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):								
	= q		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):							
	ficate be executed physician and is the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	e to (or as a consequence of):						
	ate be e nysiciar he buri	Be Completed by Physician/Medical E	· ·	d							
	nding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy				23d. Date of delivery			
	the che						Other (specify)			Month Day Year	
rds, P	ires sign d be		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 Yes 2 Mo 3 Probably 4 Unknown		
Division of Vital R	The ate h					p			Rs an utopsy findings available prior to completion of cause of death? s 12 No 1 Yes 2 No		
	ysicien: Th is certificate director, pag		25. Was case referred to medical examiner?					ath (Check only c	ne)	Assisted	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	ပု	1 ☐ Yes 2 ⚠ No	Hospital: 1 ☐ Inpat		Civity					
		on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj (Month, D	ury 28b. Time of Injury	Worl	k?	28d. Describe I	now injury occurre	d	
		icat	2 Accident investigation 3 Suicide 6 Could not b		M 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office			28f. Location (Street and Number or Rural Route Number,			
		Medical Certification;	4 Homicide determined	tc. (Specify)	reot, factory, office	City or Töwn, State)					
			29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
			29b. Signature and title of certifier	· · · · · · · · · · · · · · · · · · ·		29c. License	e number		29d. Date signed	(Month, Day, Year)	
	. 0		Meen	- Mi		D00	6175	5	6/20	111	
	10 8h		30. Name and address of person who	completed cause of	death (Item 23a) (Type					-	
			Hema latha	Nago	inna n	1.D. 70	00 H +	001e KC	1 Wester	insten IMP 2115	
	Sta Registr		31. Date filed (Month, Day, Year)	new 32. Robin	trar's Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kenneth Knapp, Jr. State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day June 19, 2011 Medical Examiner 1250 hrs Kenneth Knapp 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 1634 Forest Hill Avenue **Baltimore** 5. Social Security Number 6 Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 217-80-8302 45 Sep. 21, 1965 1 X M 2 F Country) Maryland Yrs Usual Residence of Deceden 10c. City. Town or Location 10d. Inside City Limits MD 1 Yes 2 No Baltimore hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1630 Forrest Hill Avenue 21230 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 XX No 1 Yes ö 3 Widowed 4 Divorced f Yes, Give Year Specify: White 1 Yes 2 X No specify: 5 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If item 27 is marked other than "t injury nr nther traumatic event, the Medical E Baltimore, MD 21215-0036 10 Machinist Printing Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kenneth William Knapp Sr. Marie Virginia Eyring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Houck 1909 Chipper Drive Edgewood MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Jun 25,2011 4 Donation 5 Other Specify: Atlantic Crematory Glen Burnie Maryland 21. Signature of Euperal Service Licensee 22. Name and Address of Facility Ambrose Funeral Home Inc. 1328 Sulphur Spring Road Arbutus Maryland 21227 **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death a. Hypertensive Cardiovascular Disease Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical attending physician a AMENDED 23a, pt.II, 27 per me g916 6-28-11 sm **IX UNPENDED** Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Vunknown Heroin Use Completed of Vital Records, certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 Other 5 Residence 6 🗹 Other Scene this ER/Outpatient 3 DOA 1 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the cover...
within 24 hours after death.
To the Funeral Director: A' 1 X Natural Division 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 20, 2011 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signa Registrar

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		- For State legistrar	Certificate of D	eath		g. No. 2011	2036
Physicia Medical Examir		1. Decedent's Name (First, Middle,Last) Allan M. King			2. Date of Deat Month June 4, 20	Day Year	3. Time of Death 0220 hrs
		4a. Facility Name (if not institution, give street and number)		City, Town, or Location of Deat		4c. County of Death	
F		200 N. Liberty Street 5. Social Security Number Un £6. Sex 7. Age (In		altimore Under 1 Year If Under 24Hr	la Data of Birt	h(MM/DD/YYYY) 9. Bir	thelese (State ed 17)
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nd show any		Joan State 10b. County Unk 10c	c. City, Town or Location	unk			10d. Inside City Limits LINK 1 Yes 2 No
the Maryland is or 28a-f show		IOe. Street and Number unk	10	f. Zip Code unk	10	g. Citizen of What Cour USA	ntry?
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	1. Marital Status Unlk	No If Yes, s	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puerto		White, etc.	can Indian, Black,
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once		Oa. Method of Disposition Burial 2 Cremation 3 Removal from State	20b. Place of Disposition crematory or other p	(Name of cemetery,	Date	20c. Location - City or	
Saltir smit. P epartmoporta	1	1 In turn of Funeral Scruice Line psee	tor 22. Name	and Address of Facility St	ate Anat	omy Board	
Physician	1	3a. P. rt I. Enter the disease, or com, lications that caused the		W. Baltimore			21201 Approximate Interval
/Medical		fail e. List only one cause on each line. mmediate Cause (Final disease a. Pneumonia		out of aying, out of action and o	respiratory arro	or, onsore or noun	Between Onset and Death
Examiner	-	or condition resulting in death) Due to (or as a consequence)	unce of):				
	caminer	Sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause Disease or injury that initiated c.	ence of):				
nsi ed	۱۵	ovents resulting in death) Last Due to (or as a consequence d.	ince of);				
a exe	<u>8</u>	UNPENDED AMENDED					
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. He Funeral Director: After this certificate has been signed by the attending physici applietly filled in by the funeral director, page 2 should be detached for use as the buint.		FFEMALE: bb. Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown 23c. If yes, outcome o 1 Live birth 4 Pregnant at time 9 Unknown	2 Fetal de	eath 3 Ectopic pregna	nncy	23d. Date of delivery Month D	ay Year
ing Physician: The law requires that the death After this certificate has been signed by the attimental director, page 2 should be detached for	P P	rart II. Other significant conditions contributing to death but	not resulting in the under	lying cause given in Part I.		pacco use contribute to t	
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ecol he law ate has age 2 sh	Completed				autops perform 1 ✓ Yes 2	ned? death?	ompletion of cause of
certific	98 -	5. Was case referred to medical examiner?		26 Place of Death (Check			
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On C ending eath. or: Aft		1 Natural 5 Pending (Month, Day, Year)	,,,,,	1 Yes 2 No	252. 2556.135 116	ow injury coodinate	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director.	Certification:	Suicide 6 Could not be determined (Specify)	- At home, farm, street, fac	ctory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Rur ate)	al Route Number, City
To the Hos within 24 h To the Fun completely	ल	Pa. Certifier 1 Certifying Physician: To the best of my kno ne) 2 Medical Examiner: On the basis of examina and manner stated.					
To viri on	W ?	9b. Signature and title of certifier Fundin New thal, 1903		29c. License number O.C.M.E.		29d. Date signed (Mon June 4, 2011	th, Day,Year)
		D. Name and address of person who completed cause of death Pamela E. Southall, MD Assistant Medical	'	Baltimore Street, Balti	more MD 21	223	
Sta	_	1. Date filed (Month, Day, Year) 32 Registrar's Si	ignature				- 1
Registr		JUN 2 7 2017 Revens	A. park		_		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ JÜNE 2011 DORIS KIMMEL 23 1:20 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death LIBERTY ASSISTED LIVING POTOMAC MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 🗆 M 2 🛣 Days Min. (Month, Day, Year) 03/23/1915 127-30-0653 **Director** 96 Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD MONTGOMERY 1 ☐ Yes 2x No POTOMAC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8919 LIBERTY LANE 20854 USA Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes If Yes, Give 1 ☐ Yes 2 X No Specify. "natural", 3X Widowed 4 □ Divorced Completed WHITE Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) REGISTERED NURSE MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of ပ BENJAMIN HOFFMAN HELEN NEUMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra ALAN KIMMEL/SON SPRUCE TREE AVENUE, BETHESDA, MD 20814 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) BETH ISRAEL CEMETERY 06/25/2011 WOODBRIDGE, NJ f Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. rhou 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ CONGESTIVE HEART FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HYPERTENSIVE CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Exami and burial-tra Due to (or as a consequence of): physician s the burial Physician/Medical The law requires that the death certificate be Box 68760 attending for use as as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month 1 ☐ Yes 2 🛣No Pregnant at time of death the 9 Unknown P.O. signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, DEMENTIA, DEBILITY 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 🗌 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Yes 2 X No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🔲 Yes 2 XNo 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

To the Hospital or Attending To the Funeral Director completed filled in by the

> State Registrar

29a. Certifier

(Check

29b. Signature and title

31. Date filed (Month

of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUSAN J. MILLER, 8218 WISCONSIN AVENUE, #305, BETHESDA, MD

strar's Signatu

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D35579

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

20814

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			For State Registrar	State of Mai	-	ertificate o		na Mentai ny	Reg. No.	1 1	000	
	Dhyniais	· /	1. Decedent's Name (First, Middle, Las					2. Date of De Month	eath 40	Voor	3Time of Dea	73
	Physicia Medio	cal	Bernard John		ki			June) ^{Year}	6:40 A	7 M
-	Examir		4a. Facility Name (if not institution, give		T Cont		n, or Location of	Death	4c. County		۵	
	Funeral		reater Baltimon 5. Social Security Number 6. Se	7. Age (In yrs. last birtha	ay) If Under 1 Ye			th	9. Birthp	place (State or For	reign
	Director		219-18-7363 1 1 Usual Residence of Decedent		85 Yr	S. World o	70 110015	May 20	, 1º926	Mar	ÿland	
	land show dat	호	10a. State 10b. County	1	I Oc. City, Town o	r Location				1	0d. Inside City Li	
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	eath w	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S.			n? (Specify Yes or No- Puerto Rican, etc.)			an Indian,	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ठ्व	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🄀 Divorced	Armed Forces? 1 Yes 2 □ No If Yes, Give	0	If Yes, specify C		Puerto Rican, etc.)		k, White,		
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2	filed with al Hygier d other t	امه ا	17. Father's Name (First, Middle, Last)	2yrs	Sti	ucture		eer 's Name (First, Middle	Commis		n	
Maryland 21215-0036	l be file fental rked o	인	Teofil Kulins	ki					adkowsk			
lary	should be and Menta	101	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. N	lailing Address (Stre	eet and Number	or Rural Route Numbe	er, City or Town, Si	tate, Zip C	Code)	
	and 2: Health em 27 ther tr		Cindy R. Witcza 20a. Method of Disposition	k/ Daught		Silver isposition (Name of		p Court	Timoniu			13_
nor	age 1 ent of nt: If it y or o		1 ☐ Burial 2X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemetery.	crematory or other	nlace) i 🔾	uneate 27, 2011				nd
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		21. Signature of Funeral Service Lic ms			22. Name and Ad	dress of Facility	aczorows	ki Fune	eral	Home, I	. A
m	9 9 E 18 18	Ų	14hrs 1/2	1		_		Avenue B		e,	Md.2122	22
П			23a. Part 1. Enter the disease, or comp shock, or heart failure. Vist only or Immediate Cause (Final						rest,		Approximate Interval Between Onset and Death	
24	Physician/ Medical		disease or condition resulting in death)	a. MAO Due to (or as a c		al into	venn				Jays	
	Examiner	ı.	Sequentially list conditions,	h. ————								
	ed sit	Completed by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or liniury	Cuato (cresa a	ontaction of							
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687	ertifica ding p	/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy							
30X	eath c atten d for us	iciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 4 ☐ Pregnant at ti	Fetal death	3 Ectopic pregn 5 Other (specify			23d. Dati Mor	e of delive nth	ery Day Year	
P.O. Box 68760	v requires that the death certific. been signed by the attending p should be detached for use as	Phys	9 🗌 Unknown	9 ☐ Unknown								
o.	es tha signed I be de	d by	Part II. Other significant conditions of			£4.	given in Part I.	23e. Did t	obacco use contri		e cause of death	
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tal	Physician: The law this certificate has al director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		т.		(Check only one)	2 140			
<u>></u>	Physical this call direction	일:	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 28a. Date of injury	28b. Tim	atient 3 L DOA	Other: 4 \(\sime\) Nurs	sing Home 5 Resi	dence 6 Othe)	
ouo	ading ath. Ir. Afte	icat	1 X Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation		<i>'ear)</i> inju	y w	ork?		low injury occurre	·u		
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (street, factory, office	се	28f. Location (City or Tox	Street and Numbe vn, State)	r or Rural	Route Number,	
<u>ā</u>	To the Hospital cr within 24 hours after To the Funeral Dir completed filled in		29a. Certifier 1 Certifying Phys	ician: To the best of my	/ knowledge, de	ath occured at the ti	me, date and pla	ace, and due to the ca	use(s) and manne	r as state	d.	
	he Ho in 24 h he Fur ipleted	Medical	(Check 2 Medical Examir	ner: On the basis of exar e Practioner: To the be	mination and/or in	vestigation, in my or	pinion, death occu	urred at the time, date	and place, and due	to the cau	use(s) and manner	stated.
	Neith Voirth		29b. Signature and title of certifier			29c. Lice	ense number	2	29d. Date signed			
	oth		30. Name and address of person who co	ompleted cause of deat	th (Item 23a) (Tur	e Print)	2020)	JUNE V	63	7011	
	10		ASTON 1 CVA	ARIEL M	670	IN C	horie	ST TON	Noch N	1)		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's							-	
DHM	MH 17 Rev 7/20		JUN 2 7 2011 Sen	was 19. of	parked		_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** natthette /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** 54 Director 073-72-5331 19 57 Nevis Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director ΑL Huntsville 10g. Citizen of What Country? 10e. Street and Number 1042 Stones Throw Lane 35806 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Black Specify: 2 3 Widowed 4 Divorced "natural", al Hygiene. I other than "natura went, the Medical E Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade <u>5yrs+</u> Student School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fil.
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other traumatic event,
once. Be Theophilus Monzac ည Ivy Veira 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) A. Salome James-Sister P.O. Box 651, Charlestown, Nevis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 - Other (Specify) Bath Cemetery 7/2/2011 St. Kitts, Nevis 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 Approximate Interval Between Onset and Death PONTINE HEMORRHAGIC STROKE

Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical **Examiner** YPERTENSIVE EMERGENCY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine CURINARY TRACT INFECTION The law requires that the death certificate be executed physician and Box 68760, Physician/Medical ATOR DEPENDENT RESPIRATORY FAILURE as nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy Month Year be detached for in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown ate has been sign page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one filled in by the funeral director, Be Hospital: 1 X Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury or Attending 1 Yes 2 No 24 hours after death. Funeral Director; A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hou

To the Fune

completely fi (check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number mil RES-DOD JUNE 21, 2011

State Registrar MARGARET A. OWEG!

31. Date filed (Month, Day, Year)

IIN 2 7 2011 Sum B. Gards

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

	3		For State Registrar	Please amend amend	Type or Prid #8 Per FII 24a&27 Pe	nt in B	6615 691	ndelible /2011 1 artificate o	Healt	h and N	III Copie Mental Hy	giene 0	gible.	20365
	Physicia		1. Decedent's Name (Fil	irst, Middle, Las	"e Me	nck	708	de l	Con	an	2. Date of De Month 6/4/	eath	Year	3. Time of Death 6:40p M
٠.,	Medic Examin		4a. Facility Name (if not	11.	1/	. ()	4b. City, Town	, or Location	on of Death	n 1 1	4c. Count		1 =
	Funeral		5. Social Security Numb				st birthday)	If Under 1 Ye Months Da		der 24 Hrs. s Min.	8. Data of 3 (9. Birti	hplace (State or Foreign
	Director		218-05-4662 Usual Residence of Dec	cedent		94	Yrs.				6/4/2	011		MD
	faryland 3a-f sho iffied at	Director	MD 10a. State 10l	b. County na			Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 X No
	th the N 3a or 24 t be not	al Dir	10e. Street and Number 3105 Leigh					10f. Zip Cod				10g. Citizen of	What Co	untry?
	ems 2	Funeral	11. Marital Status	TCOIT AVE	12. Was Decedent E	ver in U.S.	13.	Was Decedent of		Orlain? (Spe	ecify Yes or No-	US 14 Ra		ican Indian,
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 3 ☐ Widowed 4 ☐		Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No		If Yes, specify C	ıban, Mexi	can, Puerto	Rićan, etc.)	Bla	ck, White	, etc.
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	and 2 s Health tem 27 i		Katherine N		msay/daug				hton			more, M		1215
Baltimore,	Page 1 anent of Hant of Hant of Hant of Hury or ot		20a. Method of Disposit 1 Burial 2 C 4 Donation 5	remation 3 🗆	Removal from State	cer	metery, crer	sition (Name of natory or other p Forest		1	Date /2011	20c. Location Owings	•	· ·
alti	permit. Page Department Important: any injury o		21. Signature of Funeral			Garr	22	2. Name and Ad	dress of Fa	cility	4	300 Wab	ash A	Avenue
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Vital	cian: I ertifica sctor, p	Be	25. Was case referred to examiner?	/ h	fospital:				Place of D	eath (Check	only one)	ZZZI NO]	i Li tes	2 No
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on	ttending death. stor: Afte / the fune	Certificate:	2 Accident	☐ Pending Investigation ☐ Could not be	(Month, Day,	Year)	injury	w	ork? □ Yes 2	- 1		ion injury occur		41/15-5
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	vithi Voth	-	29b. Signature and title o		Dreel	2	1		nse numbe		97	29d. Date signe		
			30. Name and address o	of person who co	ompleted cause of de	ath (Item 2	3a) (Type, P	rint)	40	WO	Elli	and	NU PU	21042
	Stat Registra	_	31. Date filed (Month, Da	1 5 2011	32. Registrar	's Signatur	back	4					J	,

11-04180 Latonya Yvette Mo	or	Please Type or Print in State of Maryla						egible	201	2036
		- For State	•	tificate of				Reg. No.		the same that the state of the same
Physician	1	I. Decedent's Name (First, Middle,Last)					2. Date of Do Month	eath	Year	3. Time of Death
Medical Examine		Latonya Yvette Moore					June 3,	Day 2011	rear	1250 hrs
	•	 Facility Name (if not institution, give street and nu 518 Mount Holly Street 	mber)	1		or Location of De	eath	4c.	County of Deat	h
	4,	5. Social Security Number 11716. Sex	7. Age (In yrs. la	at histholous	Baltimore		Um In Data of	Dieth (2 as a #	DAGGG C B	the lane (State or
Funeral Director		216-86-8368 Jsual Residence of Decedent		35 Yrs	Months D		Min. Oct 22	,	Forei	rthplace (State or gn buntry)Mary1an
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5-0036 ed within 72 hour lygiene. other than "astu the Medical Exam	<u>.</u>	7. Father's Name (First, Middle, Last)					me (First, Middle	, Maiden S	Surname)	
215 be file be file ont, th		Warren Anthony Wadell					en Moore			
ould to		9a. Informant's Name/Relationship (Type, Print)	· 			reet and Number				
MD d 2 sh lth an lth an numed	L	Paulette Moore - aunt					Apt 2B;	Essex	x, Mary	land 21221
Fe, s l an filter filter frien for tru		0a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro		Place of Disposi rematory or oth		cemetery,	Date	20c. L	ocation - City or	Town, State
Page nent on oth	Į.	4 Donation 5 X Other Specify: in \$2.3								
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f thow injury or other traumatic event, the Medical Examiner must be notified at once. TO Re Commissed by Erinaryal Director	2	4 Cine Control Coding to	irector	and the same of th		ess of Facility 5 t		-		01001
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								204 D		

State 31. Date filed (Month, Day Year) 2011 Registrar DHMH 17 Rev 1/2001 OCME 2006

29b. Signature and title of certifier

Jack Titus MD.

30. Name and address of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

29c. License number

O.C.M.E.

June 4, 2011

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6/22/2011 4:22 PM Abdulkadir Sani Okutman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Carroll Westminster Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Country Turkey 1 X M 2 □ F Months Hours Min 67TT%1**9**22 **Director** 213-58-2849 89 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits ms 23a or 28a-f s must be notified 1 Yes 2 X No MD Carrol1 Sykesville 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 739 Obrecht Rd. 21784 USA "natural", or items edical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 **K** No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 🗆 Widowed 4 🗆 Divorced Specify: White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Doctor General Practice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Huseyin Sabri Okutman Jeanne Zahide Toumlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yorkleigh Rd., Towson, MD 21204 Sharon Brock/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Lake View Mem. Park 6/27/2011 Sykesville, MD 21. Signature of Funeral Service License Burrierd Gueen Funeral Home & Crematory, 1212 W. Old Liberty Rd., Winfield, MD 21784 Enter the disease, or complications that caused the death. Do not enter the milde of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical **Examiner** Physician/Medical Exami the burial-transit and attending physician as 2 Be ٥

Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The 24 hours after death Funeral Director. completed filled in by the

		Due to (or as a consec	juence of):				
miner	Sequentially list conditions, if any least to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as a consec	uanca o):				
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nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 - Ector	oic pregnancy (specify)		23d. Date of delive	ery Day Year
Completed by Physician/Medical Examiner	Part II. Other significant conditions o	ontributing to death but not re	sulting in the underlying	ng cause given in Part I.	1 ☐ Yes 24a. Was an autopsy	24b. Were autoprior to co	ne cause of death? bably 4 Unknown psy findings available mpletion of cause of
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Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		26. Place of Death (Che	eck only one)	-	11.
- To	27. Manner of Death		ER/Outpatient 3	DOA 4 ☐ Nursing	Home 5 Residence		1709 DIG
Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred	,
l Certi	3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fact	tory, office	28f. Location (Street a City or Town, Star		Route Number,
Medical	(Check 2 ∟ Medical Exami	sician: To the best of my know ner: On the basis of examination se Practioner: To the best of m	n and/or investigation.	in my opinion, death occurred	at the time, date and place	ce, and due to the car	use(s) and manner stated.
_	29b. Signature and title of certifier			29c License number		ate signed (Month, I	

esters/ou

21136

MI

State Registrar

within 2 To the

30. Name and address of person who completed cause of death (Rem 23a) (Type, Print)

32. Registrar's

UENCP

ATRICK 31. Date filed (Month, Day,) 11-04591 Robert Paxton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

NODER PAXION		1- For State		irtment of I tificate of L		wientai Hygiene	2 C	11 2036
Physici		Registrar 1. Decedent's Name (First, Middle,Last)				2. Date of		3. Time of Death
Medical Exam	iner	Robert a Paxton :	0			Month June 1	Day Yea 9, 2011	1115 hrs
		4a. Facility Name (if not institution, give street and r 2643 Maryland Avenue	number)		City, Town, or Los	cation of Death	4c. County of	of Death
F			7 Ago (lo um la		Baltimore	Kiladas Odlina To Data a	District of the Control of the Contr	O Birthulass (Otals
Funeral Director			7. Age (In yrs. la		If Under 1 Year Months Days	Hours Min	•	9. Birthplace (State or Foreign
- Sirector		212-80-2054 1XM 2F		49Yrs.		Jan.	7, 1962	CountrMaryland
Arab.		Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Location				10d. Inside City Limits
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h the Maryland 3a or 28a-f sho	Director	0615			·			•
vith tl s 23a e noti		2645 Maryland Ave. 11. Marital Status 12. Was De	ecedent Ever in U.S		21218 Decedent of Hispar	nic Origin? (Specify Yes or	United St	ates - American Indian, Black,
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ther d	by Fi	3 Widowed 4 Divorced If Yes, Give Ye or Dates:		1 Y	es 2 x No s	pecify:	Specify:	White
215-0036 be filed within 72 hours after death with the Maryland natal Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	d b	15. Decedent's Education (Specify only highest gra	ade completed)			(Give kind of work done) NOT use retired)	16b. Kind of Bu	siness/Industry
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and 2 sealth tem 2		20a. Method of Disposition	20b. P	lace of Disposition	n (Name of cemete	ery, Date		Maryland 21228 City or Town, State
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Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify: 2 Sign were of Funeral Service Licensee	Atl	antic Ci	ematory e and Address of I		011 Glen B	urnie,Maryland
Baltimo permit. Page Department i Important:		Tolling and Bl	ach C				LANSDOWNE	, Maryland2122
Physician		23a. Part I. Enter the disease, or complications that failure. List only one cause on each line. Mu	caused the death.	Do not enter the	node of dying, suc	h as cardiac or respiratory	arrest, shock, or hea	rt Approximate Interval
Medical		failure. List only one cause on each line. Mul Immediate Cause (Final disease aluetial	tiple dr	ug toxic	ty invol	ving mirtaze ne,and cutti	pine os iniuri	Between Onset and Death
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	힅	cause. Enter Underlying Cause	a consequence of)):				
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376 ficate g phy s the b		3b. Was decedent pregnant in the	outcome of pregna		leath 3 E	Ectopic pregnancy	23d. Date of o	delivery Day Year
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ords w requires been a should	Completed					24a. Wa au		ere autopsy findings available for to completion of cause of
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(ospit)		29a. Certifier	RODIGER					
Division of Vital Records, P.O. Box 68760, To the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi	Medical	(Check only one) 2 Medical Examiner: On the basis	of examination and					
S skir 3	₹	and manner s 29b. Signature and title of certifier	stated.		29c. License nu	mber	29d. Date signer	(Month, Day, Year)
		6)/-6///6)	1/1/30	A	O.C.M.E		June 20, 20	11
	}	30. Name and address of person who completed cause	se of death (Item 2	?3a)	<u> </u>			
					altimore Stree	et, Baltimore, MD 21	223	
			egistrar's Signature	9				
Regist		JUN 2 7 2011	A. A.	and				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death DENWAL Baltimore Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 1 - M 2XX F Days Min. 91 021/141/1920 ear) Mary Tand **Director** 220-07-7581 Usual Residence of Decedent 28a-f shov ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Yes 2 No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21286 USA 800 Southerly Road Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Who If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: 3 Widowed 4 Divorced "natural" Completed White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) School Cafeteria Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James William Shea Elizabeth Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son-In-Law 10330 Pinehurst Court Ellicott City, Maryland 21043 Thomas Hook 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial XX Cremation 3 - Removal from State GreenMount Crematory 06/28/2011 Baltimore, Maryland Donation 5 Other 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ture of Funeral 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one gause on each line. shock, or heart failure. List only one Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) TASTATIC 10NTH 5 Medical Examiner Sequentially list conditions, it can be single to in a clistocause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 mon Day Year Pregnant at time of death 2 No 9 Unknown a Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DOMONTIA 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate has 2 1 No 1 Yes Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 1 ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 🚾 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State Registrar address of person who

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:15 P_M June 16^{Day} 201^{Year} William B. Rollins Sr Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 5918 Moorehead Road Catonsville 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Hours Min. Nov . 29 Maryland 1924**Director** 218-18-9701 86 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore Catonsville 1 ☐ Yes 2 XNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5918 Moorehead Road 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Baltimore City Police Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other trees. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James G. Rollins Sr. Charlotte Biddison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5918 Moorehead Road, Catonsville MD 21228 Martha Sergent Rollins-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State Atlantic Crematory Jun 20,2011 Glen Burnie 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home Inc <u>|| 1328 Sulphur Spring Road Arbutus Marvland 21227</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death CANCER Ph sician/ -IVER disease or condition resulting in death) MONTH Medical Due to (or as a consequence of): **Examiner** MONTHS HODER Sequentially list conditions Examiner It any, leading to immediate cause. Enter Underlying Due to (or sele consequence of) signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant a Day 5 Other (specify) Pregnant at time of death Month Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an cate has to page 2 s autopsy performed' death? this certificate 2 🗆 No 1 🗌 Yes 25. Was case referred to medica examiner? **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ျ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 Natural 5 Pending Accident 1 Yes 2 No after death Investigation 6 Could not be Suicide within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 🗆 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

RABINA 31. Date filed (Month, Day, Year)

MALIK 32 Pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 724

MEDICALDOGRA DOO6350

MAIDEN CHOICE LANE CATONSVILLE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Peyton Joey Riv		Sta 1- For State Registrar	ate of Maryla	nd / Depa	artment of ertificate of	Health and	d Mental		teg. No. 2	011 2037
Physicia	an/		e,Last)					2. Date of Dea		3. Time of Death
Medical Exami	ner	Peyton Joey R: 4a. Facility Name (if not institution				0.7	Landing of Dec	May 31, 2	2011	UTT/ nrs
		John Hopkins Bayview				b. City, Town, or Baltimore	Location of Dea	itn	4c. County of	of Death
Funeral		5. Social Security Number Unit		7. Age (In yrs.	last birthday)	If Under 1 Year	r If Under 24H	Irs. B. Date of Bi	rth (MM/DD/YYYY	9. Birthplace (State or
Director			1X M 2 F	34	Yrs.	Months Days	s Hours M	in. April	26, 1977	Foreign Country Virginia
8		Usual Residence of Decedent								
W any		10a. State 10b. County			, Town or Location	on				10d. Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show 1 at once.	ţ	MD 10e. Street and Number		Ва	altimore	406 75- 0- 1-			10. 02614/6	
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	Director	14 Decker St				10f. Zip Code 21213			10g. Citizen of Wh USA	nat Country?
with the 13s oc noti		11. Marital Status		edent Ever in U		Decedent of His			o- 14. Race	- American Indian, Black,
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after	by		rced If Yes, Give Year or Dates:			Yes 2 X No			Specify:	black
5-0036 led within 72 hours Hygiene. other than "natur:		15. Decedent's Education (Speci				's Usual Occupati est of working life.			16b. Kind of Bus	siness/Industry
36 nin 72 s. than dical	ple	Elementary/Secondary (0-12)	College (1-	-4 or 5+)	anch	100			Pareco	- Vina
5-00 led with Hygiene other	Completed	unk 17. Father's Name (First, Middle, I	unk ast)		cash		IB.Mother's Nan	ne (First, Middle,	Maiden Surname)	r King
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be (Ronald Lee Riv	ers				Diane	Ashby		
D 21 t should and Me 7 is man	유	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailing	Address (Street	t and Number o	Rural Route Nur	mber, City or Towr	n, State, Zip Code)
≥ 6 g g g g	ļ	April Ellerbe 20a. Method of Disposition	- friend			N. Decke		Baltimo:		land 21224
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 Burial 2 Cremation	3 Removal fro		crematory or oth		netery,	Date	20c, Location -	City or Town, State
ti. Pag tment rtant:		4 Donation 5 X Other Spe	city: in sta	tø/	Lan					
Baltimorr permit. Pages 1 Department of 1 Important: If		21. Signature of Funeral Service L Ronal d	S. Wade,	Directo	22. Na	ame and Address	of Facility St	ate Anat	omy Boar	:d
Physician		23a. Part I. Enter the disease, or o		used the death	n. Do not enter th	e mode of dying,	LT1more such as cardiac	or respiratory arr	timore. est, shock, or hea	
/Medical		failure. List only one cause of Immediate Cause (Final disease	n each line. a. Gunshot Wo	ound of Che	est					Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a							
	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	000000000000000000000000000000000000000	s.£\;					
	nine	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a	consequence o	σ).					
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oe executed crian and irral - transi	dical	UNPENDED	dAMENDED							
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ox 6 eath ce attend for use	Sici	1 Yes 2 No 9 Unkn	1 '=	nt at time of de	eath 5 Oth	er (Specify)			1	
the de ched for the de	Physician/Me	Part II. Other significant condition	9 Unknow		esulting in the un	iderlying cause gi	ven in Part I	23e. Did to	bacco use contrib	oute to the cause of death?
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate to the Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu	ğ	•				,			s 2 ✓ No 3	
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ing Ph	ᇣ	27. Manner of Death	28a. Date o	of Injury Day, Year)	28b. Time of Inj	ury 2Bc. Injury	y at Work?	28d. Describe I Subject sho	now injury occurre	d
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ल	(Check only 1 Certifying Phy	sician: To the best iner:On the basis of							
To To con	¥ -	29b. Signature and title of certifier	and manner sta	ated.		29c. License	number		29d. Date signe	d (Month, Day, Year)
		(andl	4-10 DC	an		O.C.M	1.E.		May 31, 201	
	+	30. Name and address of person w	no completed cause	of death (Item	1 23a)					
			stant Medical E				Baltimore, M	1D 21223		
Sta Regist	ate rar	31. Date filed (Month, Day Year) 2	011 37 Rec	jistrar's Signatu	: par	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month FRANCES W. ROLFES 06 19 2011 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pear Tree Living Pasadena Arundel Assisted Anne Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 8. Date of Birth 6. Sex Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 F Days Months Hours Min. 3/21/1912 Country) 99 218 12 6968 MD Director Usual Residence of Decedent or 28a-f shov 10b. County 10d Inside City Limits 10a, State 10c. City. Town or Location Examiner must be notified at Director 1 Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? items 23a Funeral 232 Kenwood Rd 21122 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married "natural", or Saltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates Specify. Specify: 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l th and Mental Hygiene. 77 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Wire builder-assembler Western Electric other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frederick Wacker Mary Rachuba 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Geraldine Wedemeyer/daughter 232 Kenwood Rd Pasadena. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 📈 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Oak Lawn Cemetery! 6/23/11 Baltimore, Signature of Funeral Social Licensee 22. Name and Address of Facility GJ Gonce Funeral Home 21122 169 Riviera Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Anset and Death Immediate Cause (Final Physician/ Cula disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of liftjury that initiated events Due to (or as a consequence of) Examil that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Month Day ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed Yes 2 this certificate 2 100 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 2 19 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and file of certifier

31. Date filed (Month, Day, Year)

7

30. Name and address of person who completed

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:15 AM balnik Month 20 il 1 a Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** evindale Gervatric N/A Center Ba If Under 1 Year | If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 A F Days 212-53-6420 84 Months Hours Min. 0997771926 UKRAINE Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6952 MILBROOK PARK DRIVE #2A 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. WHITE Specify: 3 Midowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **PROKOP** SKRIPKA NATA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2937 KATEWOOD COURT, BALTIMORE, MD 21209 ADRIAN RYBALNIK/GRANDSON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 💹 Burial 2 🗌 Cremation 3 🗆 Removal from State ARLTNETON OF ARTHUR OF ART 06/23/2011 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 . Signature of Funeral Service Licenses Lichard 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arterioscleromo Cardiovascular Physician/ Medical resulting in death) Due to (or as a consequence of) entroucen Examiner Sequentially list conditions any, reading to immediate cause. Enter Underlying Due to for as a consequence of, Exami Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last the burial-trai Due to (or as a consequence of): attending physician Physician/Medical Pivision of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 🗷 No been signed by the atte Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate 1 ☐ Yes 2 ☐ No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? after death. 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 34 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar DHMH 17 Rev 7/2009 29b. Signature and title of certifier

31. Date filed (Month, Day,

M. Eletta Morse CRUP

Le Na mouse CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2434 W.

29d. Date signed (Month, Day, Year)

Belvedere Ave, Balkimore MO 21215

29b. Signature and title of certif. ,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m 1132 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Registrar

State

CEAME LANE

6336

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MD

31. Date filed (Month, Day, Yea

JUNE 24, 2011

COLUMBIA, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 21 Meta Marie Spadaro June 9:07 am M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Best Care Assisted Living Baltimore Reisterstown Social Security Number If Under 1 Year I If Under 24 Hrs. . Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🎗 F Hours Country 546-40-7520 Director 93 4-20-1918 Germany Usual Residence of Decedent 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Reisterstown 1 Yes 2 X No 0 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 639 Main Street 21136 United States items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces Black, White, etc. ō by 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: "natural" Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed, r than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Supervisor Insurance other Be 17. Father's Name (First, Middle, Last) Ith and Mental H
27 is marked ot
r traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Haas Katherine Rubke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Joanne M. Boortz (daughter) 9725 Sherwood Farm Rd. Owings Mills, MD 21117 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō \square Burial 2 $\raisebox{.5ex}{\begin{tabular}{l} \hbox{Σ} \end{tabular}}$ Cremation 3 \square Removal from State = 5 Department or Important: If any injury or Donation 5 Other (Specify) Carroll Cremation 6-24-2011 Hampstead, MD of Funan 22. Name and Address of Facility ELINE FUNERAL HOME J. Wayne Osterling 11824 Reisterstown Rd. Reisterstown, MD 21136 Part 1. Enter the e, or complications that caused the death. Do not enter the make of dying, such as cardiac or respiratory arrest Approximate shock, or heart fail Interval Between Onset and Death Immediate Cause (Final Ph. sician/ resulting in death Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death detached the ☐ Unknowr þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed the should be det 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 1 Yes 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? 2 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DQA Nursing Home 5 Residence 6 Other (Specify) Director: After this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Mapner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No} Natural 5 Pending injury after death М Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

completed

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State

(Check only one)

29b. Signature and title of ertifier

Name and address of person who completed

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Leftlying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

G

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Barbara A. Stone 01 6/24/2 2:02A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Gilchrist Hospice 8. Date of Birth (Month, Day, Yea 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 1 🗆 M 2 💢 F Country) 213-32-8104 75 **Director** Ĩ936 5/10/ Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Examiner must be notified 1 X Yes 2 No N/A Baltimore MD 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 21239 Funeral 23a 1538 E. Belvedere Ave. USA items 2 Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 ☐ Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Black "natural", Specify: Completed 3 Divorced 4 Divorced and Mental Hygiene.
I is marked other than "natur raumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Baltimore City yrs. Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Phoebe Henderson Cornelius Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1638 Lyle Ct. Parkville, MD 21234 Health tem 27 i Valeria McIntyre-Sister item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Loudon Park Cemt. 6/28/2011 Baltimore, MD 22. Name and Address of Facility March F/H 1101 E. North Signature of Taneral Service Licenses Ave. Baltimore, MD 21202 Ele 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death Immediate Cause (Final Physician/ Cance ancrean disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) resulting in death) Last physician by Physician/Medical P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery ó in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown Division of Vital Records, 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 st autopsy performed? 1 Yes Director: After this certific d in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner' Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 9d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARVES MI V225mst 670

DHMH 17 Rev 7/2009

State Registrar 32. Redistrar's Signature

11-04712 Maveen Scott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #State of Maryland / Department of Health and Mental Hygiene

viaveen Scott		1- For State Registrar	e or iviaryianu		tificate of De		To Triorita.		Reg. No	2011	20378
Physicia		Decedent's Name (First, Middle,L	ast)	_	- .			Date of De Month	ath Day	Year	3. Time of Death 0700 hrs
Medical Exami	ner	Maveen 4a. Facility Name (if not institution,	give etreet and number	1		ott	or Location of Deat	June 24,	2011	c. County of Death	
		3245 Gulfport Drive	give street and number	,		ltimore	or Eccation of Deat			c. Ocurry or Boatt	'
Funeral			Sex 7. Ag	ge (In yrs. Ia		Inder 1 Ye			lirth (MM	I/DD/YYYY) 9. Bir Foreig	an
Director			M 2_XF	48_	Yrs.	oriuis Da	lys Hours IVIII	11	15	62 ^{co}	untry) PA
Anty		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location				-		10d. Inside City Limits
≥ 1	5	MD Balt	imore	£	altimor	e Bro	ooklyn				1 X Yes 2 No
Maryla	Director	10e. Street end Number			10f.	Zip Code			10g. Cit	tizen of What Cou	ntry?
th the 23a or		3245 Gulford D			140.111		225			U.S.A.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 37 is marked other than "natural", or items 33a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Marri	12. Was Decedent	?		edent of H ecify Cuba	lispanic Origin? (S an, Mexican, Puert	pecify Yes or N Rican, etc.)	0-	14. Race - Amer White, etc.	ican Indian, Black,
ffer de	by Fu	3 Widowed 4 Divorce	1 Yes 2 lif Yes, Give Year or Dates:	X No	1 Yes	2 X N	o specify:			specify: Bla	ck
hours s	D D	15. Decedent's Education (Specify	only highest grade con		16a. Decedent's Us during most of		ation (Give kind of e. DO NOT use re		16b.	Kind of Business/	ndustry
36 iin 72 l	Completed	Elementary/Secondary (0-12) 12th grade	College (1-4 or na	5+)	Custom	er S	ervice	·		Hotel	
21215-0036 uld be filed within 7 Mental Hygiene, marked other than c event, the Medica	S	17. Father's Name (First, Middle, La					18.Mother's Nam	e (First, Middle,	Maider		
121 be fill ental H rrked	8	L.C. Scott					Joan C				
D 2 should and Ma 7 is m	٤	19a. Informant's Name/Relationship					et and Number or				
and 2 sho lealth and ticen 27 is traumati		Manyell Akinf 20a. Method of Disposition	e-Niece	20b. P	lace of Disposition (Name of ce	Street	Date		Location - City or	
Baltimore, permit. Pages I an Department of Hea Important: If ites		1 Burial 2 Cremation 4 Donation 5 Other Speci		"" Pit	rematory or other pla tsburgh	Cre	mation	1 /2011	n		ark D3
altir mit. I partme	Ì	21. Si hat re of Funeral Service Lic		ISOY	Vice 22 Name a Marc	and Address	ss of Facility H West	1//011	ПЪ	ittsbur	an, PA
	Ц	Julynes	-B- Ref	e	14300	Wab	ash Ave	, Balt	imo	ore, Md	
Physician /Medical		23a. Pa 1. Enter the disease, or confailure. List only one cause on									Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a.ruptured a Due to (or as a conse			anter	ior commu	nicatir	ig ai	rtery	
	J	Sequentially list conditions,	b								
	흘	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consec.	equence of)	:						
ed Isit	Examine	events resulting in death) Last	Due to (or as a conse	equence of)	:						
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	<u>s</u>	▼ UNPENDED	d	a,27,p	er me,g91	8 8-5	5-11 sm				
760, cate be physici	Med	IF FEMALE:	23c. If yes, outcor						23	d. Date of delivery	,
certification and inguise as t	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth A Pregnant at	time of dea	2 Fetal dea		Ectopic pregna	ancy		Month D	ay Year
Box 687 e death certific	Physician/	1 Yes 2 No 9 V Unknow			J Uther {S	pecity)					
that the	by P	Part II. Other significant condition	s contributing to deati	h but not re:	sulting in the underly	ring cause	given in Part I.		tobacco es 2		the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. **In Director**. After this certificate has been signed by led in by the funeral director, page 2 should be detach	핗							24a. Was			topsy findings available
tal Records, cian: The law requii certificate has been : ector, page 2 should	Completed							auto	psy ormed?	prior to death?	ompletion of cause of
tal Religion: The certificate		25. Was case referred to medical				26 Place	e of Death (Check	1 Yes	2N	lo 1 🗸 Ye	s 2 No
Vita ysician his cer directo	B Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	ent 2 🔲 i	ER/Outpatient 3	DOA	TOther -	ng Home 5	Reside	ence 6 🗸 Other	Scene
1 of Jing Ph After ti funeral	٩	27. Manner of Death	28a. Date of Inju (Month, Day,Y	ıry 'ear)	28b. Time of Injury		ury at Work?	28d. Describe	how inj	ury occurred	
Sion Attend death. ctor:	텵	1 X Natural 5 Pending 2 Accident Investiga	ation				Yes 2 No				
Division ospital or Attentions after death nours after death nucral Directors y filled in by the	Certification:	3 Suicide 6 Could no determin	ot be	ijury - At nor	me, farm, street, fact	ory, office i	building, etc.	or Town,		and Number of Ru	ral Route Number, City
Hospit 24 hour Funera		4 Homicide 29a. Certifier 1 CertifyIng Phys	iclan: To the best of m	y knowledge	e, death occurred at	the time, d	late and place, and	due to the cau	se(s) ar	nd manner as state	ed.
To the Hospi within 24 hou To the Funes completely fil	Medical	one) 2 Medical Examin	ner: On the basis of examend manner stated.	mination an	d/or investigation, in	my opinior	n, death occurred	at the time, date	and pla	ace, and due to the	e cause(s)
	Σ	29b. Signature and title of certifier	V			29c. Licens	UN	ìE		Date signed (Mor	nth, Day, Year)
		Theodore M.	Right T	Le M	200	U.U.	.M.E.		Jun	e 24, 2011	
ŀ		 Name and address of person wh Theodore M. King, Jr., M 	200		^{23a)} xaminer 900 \	N. Baltir	more Street, B	altimore, M	D 212	23	
Sta	-	31. Date filed (Month, Day, Year)			barker		•				
Registi		11 14 CT 17 DD44	P1.	25 A	THE REAL PROPERTY.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MO016-14-2011 Year 12:38 PM Wylie James Spencer Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Prince George's Hospital Ctr. Cheverly Prince George's 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min 08-26-1951 264-06-0643 59 **Director** MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No MD Prince George' Bladensburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5200 Quincy St., Apt. #206 20710 U.S. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thrany or other traumatic event tto. Government Years Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wiley Spencer Willie Maude Milton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shantarra Benyard/Daughter 2009 Plainfield Dr. SW/Vero Beach, FL 32965 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🖼 Removal from State Lakeland Mem. Cem. 7-2-2011 4 ☐ Donation 5 ☐ Other (Specify) Lakeland, FL Signature of Funeral Service Lice 22. Name and Address of Facility Tri-State Funeral 814 Upshur St., NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin -transit Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Yes 2 No 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 🕽 No Other: ၉ 1 Yes 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury s after death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

Division of Vital Records, within 24 hours a To the Funeral D

30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print) SCHROE DER ERIKA 3001 HOSPITAL 31. Date filed (Month, Day,

State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d Date signed (Month, Day, Year,

	_ For	Please	Type or Pri		Departmen	nt of H	ealth and N	•	_	ible.	
	1 - State Registrar				Certificat	te of L	Death		g. No.		20380
an al	1. Decedent's Name (Firs		,					2. Date of Deat Month	Day	Year O !!	3. Time of Death
er	4a. Facility Name (If not in	stitution, give	e street and number)		4b. City,	,	Location of Death		4c. Count		
	FRANKLIN S						sedale				nore
	5. Social Security Number 217-60-33 Usual Residence of December 1	51 1	ex	e (In yrs. last bir 1	Yrs. Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	930	9. Biri	thplace (State or Foreign ountry) MD
		County	_	10c. City, Town	n or Location						10d. Inside City Limits
tor	MD Ba	ltimo	re	Middl	e River	r/Es	sex				1 XYes 2 ☐ No
Director	10e. Street and Number				10f. Zip	Code		11	Og. Citizen of	What Co	ountry?
al D	1829 Kitt	yhawk	Road		212	221			USA		
Funeral	11. Marital Status		12. Was Decedent Armed Forces?		13. Was Dece	dent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-			erican Indian,
	1 Never Married 2	Married Married	1 Tyes 2 T		1 🗆 Yes		Specify:	rnoari, otc.)		ack, White <i>ify:</i> Wh	
d by	3 ☐ Widowed 4 ☐ D	ivorced	Year or Dates:		12103		орсону.		Spec	iy. WIII	1116
ete	15. D (Specify onl	ecedent's Ed y highest gra	ucation de co <i>mpleted)</i>	16a.	Decedent's Usu (Give kind of wo	al Occupa ork done d	ation luring most of work)	ing	16b. Kind of I	3usiness/	/Industry
Completed	Elementary/Secondary	(0-12)	College (1-4or 5	,)		0		
	17. Father's Name (First, i	Middle Last)			Homema)	ker	18. Mother's Name	First Middle M		n Ho	ome
Be		,								11107	
ပ္	Arthur Ja			10h	Mailing Address	(Stroot o	Georgi and Number or Rur	ana Sir		n State	Zin Cada)
	Jim Venke		• •		-				-		
	20a. Method of Disposition		rocher-1								Town, State
	1 □ Burial 2 □ Cren	nation 3 🗆		Holl	Disposition (Narry, crematory or o	other place Cem	6-24	_11 l	4iddl	e Ri	ver, MD
	4 Donation 5 □ C			11022							neral Hom
	21. Signature of Funcial C	1//	300				Willow				
	23a. Part 1, Enter the dise	ase, or comp	plications that caused	the death. Do r						, .	Approximate
1	shock, or heart failu Immediate Cause (Final	re. List only	one cause on each li	ne.	_		9,		,		Interval Between Onset and Death
	disease or condition resulting in death)	-	a. Respira	a consequence	ailun	۲				_	unknown
			b. Chroni			e :	1 mana	car di	seas		unknowi
ē	Sequentially list conditions	S,		a consequence		- 1	UL MONE	7	J (_ C()		CHAROOT
Ē	if any, leading to minedial cause. Enter Underlying Cause (Disease or injury that initiated events	1	. cardi	ac fo	ilure						
Examiner	resulting in death) Last		Due to (or as	a consequence	of):						
ca			d. Cong	estive	: hear	TE	failure				
edi											
Š	IF FEMALE: 23b. Was decedent pregn		23c. If yes, outcome	of pregnancy	3 ☐ Ectopic p	roanono			23d. D	ate of de	elivery
sician/Medical	in the past 12 month 1 ☐ Yes 2 ☑ No	s?	4 ☐ Pregnant a		5 ☐ Other (sp				, N	/lonth	Day Year
≥	9 Unknown		3 GUNIOWII			_					
by P	Part II. Other significant of	conditions o	ontributing to death b	ut not resulting ir	the underlying c	ause give	n in Part I,				o the cause of death?
								1 🗆 Ye	s 2 No	3 □ P	robably 4 onknown
ompleted								24a. Was ar autops		. Were a	utopsy findings available completion of cause of
E								perform	ned?	death?	s 2 □No
BeC	25. Was case referred to rexaminer?	nedical					26. Place of Deat				
၉	1 Yes 2 1 No		Hospital: 1 Impatie	ent 2 ER/Ou	tpatient 3 DC	Othe	er: 4 🗆 Nursing Ho	me 5 Reside	nce 6 🗆 O	ther (Spe	ecify)
	27. Manner of Death	Pending	28a. Date of Inju (Month, Da	ry 28b. 7	Time of 2	28c. Injury Work	at ?	28d. Describe ho	w injury occu	ırred	
Certification:	2 Accident	investigation			М		res 2□No				
₩ ₩	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e, Place of Inj	ury - At home, fai c. <i>(Specify)</i>	rm, street, factory	y, office		28f. Location (St City or Town	reet and Nun , State)	nber or R	tural Route Number,
9									· · ·		
Medical	29a. Certifier 1 C (Check only one)	ertifying Ph ledical Exam	ysician: To the best iner: On the basis o and manner st	f examination an	, death occurred d/or investigation	at the tim	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and a ate and place	manner a	as stated. e to the cause(s)
Me	29b. Signature and title of	certifier			290	c. License	number	2	9d. Date sigr	ied (Mon	th, Day, Year)
	> Yali	na Z	hang, 1	M.D.		DAC	0605		June.	20	, 2011
}	30. Name and address of		completed cause of d	leath (Item 23a) (Type, Print)				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	DR Yuling		ng 90	OO FAN	inklin	SQU	ice 6 = De	3 Boli	to u	id	21237
е	31. Date filed (Month, Day		32. Figistr	ar South		24 27		10-00			
ar	JUN 2 7 2017	per	Mr. 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 4a, b / per doc 2917 7-7-11 ye State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Degedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month EIDLER NUT Medical 4a. Facility Name (if not institution, give street at Anne. Arundel Medical 4b. City, Town, or Location of Death Annapolis Examiner 4c. County of Death timore <u>Anne</u> Arunde] Social Security Number If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 - F 213 30 1660 Months Days 0971571933 Country) Director Yrs MD Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No Anne Arundel Pasadena 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 706 East Shore Road 21122 U.S.A. 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 🗷 Yes 2 🗆 No 1952 -Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 M No Specify: 3 Widowed 4 Divorced Specify: Completed 1956 White the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) permit, Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the In Maintanance Machinist Locke Insulators Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Adam Victor Seidler, Sr. Martha Alva Brannock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Seidler - Wife 706 East Shore Rd Pasadena, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk! 6/24/11 Glen Burnie, MD 21. Signature of Foreral Service Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, P Prive Pas<u>adena, MD 21122</u> Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ on disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if n cause. Enter Underlying Cause (Disease or iinjury Examiner Due to lor as a nonsequence of the attending physician and hed for use as the burial-transit Hespital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ODivision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 2 No 1 ☐ Yes 2 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed?

Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: ပ္ 1. Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work' Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie am Name and address of person who completed cause of death (Item 23a) (Type, Print) twy ANNAPOUS INTA 445

Registrar DHMH 17 Rev 7/2009 -Ci

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0523 AM 2011 Tune Medical 4a. Facility Name (if not institution, give street and **Examiner** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign -20-240 Hours **Director** Jun 14: 1924 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland must be notified at 10d. Inside City Limits Director 1 Tes 2 No ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral ral", or items 23a Examiner must b 12. Was Decedent Ever in U.S. Armed Forces?

1 Les 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Completed by Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Vivorced ach Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 1 Tay Be 17. Father's Name (First, Middle, Last) ame (First, Middle, Maiden Surname မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Thompson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) O Funeral Service Licensee ure 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Medical s a consequence of): Examiner Preumonia ration mins Sequentially list conditions, if at y, leading to increalist cause. Enter Underlying Examiner had for use as the burial-transi hour Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autonsy Yes 2 No Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 X DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 \square Pending injury within 24 hours after death. To the Funeral Director: Al Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0053373 June 24 2011 201 East University Parkway 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital MID Rattimore

State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death tate 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20:47 RANDOLPH Medical TATE 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Haspital Battimore Boultimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day Year) | 07-05-1939 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 XM 2 F Director <u>220-36-7159</u> 71 MD Usual Residence of Deceden items 23a or 28a-f show her must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7206 CHALKSTONE DR. APT T3 21208 U.S.A. "natural", or iter ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No If Yes, Give 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: Year or Dates BLACK is marked other than "natur aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) CORRECTIONAL OFFICER CORRECTIONS Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JAMES PIERCE TATE VIVIAN TATE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LATISHA_WHITE/DAUGHTER 4646 WALTHER AVE. BALTIMORE, MD 21214 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ARBUTUS 07-01-2011 MEM. PARK BALTIMORE, MD 21. Si nature of Funer I Service Lice 19ee 22. Name and Address of Facility
WILLIAM C. BROWN COMMUNITY FUNERAL HOME P.A.
1206 W. NORTH AVE. BALTIMORE, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Acute respiratory failure disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Preumonia 3 weeks Sequentially list conditions, it any begins to immediate cause. Enter Underlying Physician/Medical Examiner Divi to (or as a nonsequence of) sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Artery Disease Atrial 1 Yes 2 No 3 Probably 4 Unknown Completed Diabetes nellitus Deep vein thrombosis 24a. Was an 24b. Were autopsy findings available autopsy performed Yes 2 No prior to completion of cause of death? 2 140 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manual of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred / Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 June 25, 2011 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABADIWA, MO KATRINA SINAL HOSPITAL OF BALTIMORGE

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

7 2011

Theodore

Sp

Patient P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Illen Edward Ti	hom	pson, Jr. 1-For State Registrar	St	tate of Mary	and / D	Department o Certificate o		and Me	ental Hy	_	Reg. No.	201	20	38
Physici		1. Decedent's Name							1	2. Date of Dea		Year	3. Time of Dea	
Medical Exam	iner			Thompson,						June 4, 2	011		1715 hrs	
		4a. Facility Name (i		on, give street and n	umber)		4b. City, Town, Arnold	, or Location	on of Death			county of De		
Funeral		Social Security N	•	6. Sex	7. Age (Ir	n yrs. last birthday)	If Under 1 Y	Year If U	nder 24Hrs.	8. Date of B			Birthplace (State of	riink
Director				1XM 2_F		54 Yrs	Months E		ours Min.	Dec 28		Fo	reign Country)	
any		Usual Residence of 10a. State	10b. County	unk	100	c. City, Town or Locat	ion unk						10d. Inside Cit	ty Limits
	_	MD											1 Yes 2	2 No
faryla 28a-f	Director	10e. Street and Nur	mber unk				10f. Zip Code	e unk		1	10g. Citize	n of What C	ountry?	
with the Maryland ms 23a or 28a-f sho be notified at once											USA	A		
5-0036 led within 72 hours after death with the Maryland Jygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Funeral	11. Marital Status		12. Was De	cedent Eve orces? <u>u</u> 1		s Decedent of es, specify Cut				0- 14	I. Race - An White, etc	nerican Indian, Blad	ck,
or deat	Fun	1 Never Marrie	_	1Yes	2					tiouri, cic. j				
rs afte	by	3 Widowed 15. Decedent's Ed		orced If Yes, Give Ye or Dates: cify only highest gra		ted) 16a Deceder	Yes 2 X			ork doneUTI		ecify: W	ss/Industry Unk	
2 hou	Completed	Elementary/Seco			1-4 or 5+)		ost of working				TOD: TOT	a or basine.	sarii (dasti y	
5-0036 led within 72 h Hygiene. other than "n. the Medical E.	mp	unk		un	k									
5-0 iled w Hygic		17. Father's Name ((First, Middle,	Last) unk				18.Moti	her's Name (First, Middle,	Maiden Su	rname) U	ık	
21215-0036 wild be filed within 7 Mental Hygiene. marked other than	D Be	19a. Informant's Na	mo/Polations	hin /Type Print \		10h Mailin	Address (O		b			T 0:		
그 유명 등 열	2	O.C.M.H		inp (Type, Fint)			W. Ba						ate, Zip Code) 21223	
ore, ME ss 1 and 2 s of Health as of Health as If item 27		20a. Method of Disp	position			20b. Place of Dispos	ition (Name of			Date			or Town, State	
Baltimore, Demit. Pages I an Department of Hea Important: If iter				Removal f		crematory or other	ner place)				İ			
Baltimo permit. Page Department o Important:		4 Donation 5 21. Sig e re of F	ral rvice	Licensee	111	22. N	lame and Addr	ess of Fac	ility Stat	te Anat	Omv 1	Board		
E P P P	U	Sin			rec		55 W. I						21201	
Physician		23a. Hart I. Enter the filture. List onl			aused the	death. Do not enter t	ne mode of dyir	ng, such a	s cardiac or I	respiratory an	est, shock	, or heart	Approximate Between On:	
/Medical ≟xaminer		Immediate Cause (F				otic Cardi	ovascu	lar D	iseas	e			Death	
		or condition resulting		Due to (or as	a conseque	ence of):								
	ĕ	Sequentially list cor if any, leading to im	mediate	Due to (or as	a conseque	nce of):							1	-
	Examiner	cause. Enter Under (Disease or injury the events resulting in or	nat initiated	c. Due to (or as	conseque	ince of).								
cecuted n and - transit	_	events resulting in t	ueatii) Last	d.	4									
D, be executed sician and nurial - transi	dical	X UNPENDED		AMENDED	23a,2	7,per me,g	916 6-2	28-11	sm					
760 icate b physi		IF FEMALE: 23b. Was decedent p	pregnant in th			f pregnancy					23d. D	ate of deliv	ery	
ox 6876C eath certificate attending phys for use as the b	Sia	past 12 months		ı 🗀 rive i	oirth nant at time	of death	ar acatri	3Ecto	pic pregnan	СУ	Me	onth	Day Ye	ear
Box 6876(e death certificate the attending phy-	Physician/M	1 Yes 2 N	lo 9 🔲 Unk	nown 9 Unkn		5 <u></u> ∪ 0ti	ner (Specify)							
, P.O. res that the signed by the be detached	DY P	Part II. Other signif	icant conditi	ions contributing t	o death but	not resulting in the u	nderlying caus	e given in	Part I.				to the cause of dea	
S, P	P P									1 Ye:	s 2 N	lo 3∐P	robably 4 🗹 Unk	known
ords w requi	Plet									24a. Was autop	sy	prior t	autopsy findings a o completion of cau	
Rec The la	Completed									1 ✓ Yes	rmed? 2 No	death		No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by tee funeral director, page 2 should be detach.	BB	25. Was case referre examiner?	ed to medical	Hospital:					th (Check on	<u> </u>				
Physical direction	리	1 ✓ Yes 2 27. Manner of Death	No No	28a. Date	of Injury	2 ER/Outpatient 28b. Time of Ir		njury at Wo	Nursing	Home 5 8d. Describe		occurred	ner: Scene	
on of ading Ph	Ë	1 X Natural	5 Pend	(Month	, Day Year)	ZOD. TIMO OF II	· · _	Yes 2	_	od, Describe	now injury	occurred		
r Atter	ertification:	2 Accident		tigation 28e. Plac	e of Injury	- At home, farm, stree				8f. Location (Street and	Number or	Rural Route Numbe	er. City
Div	E	Suicide 4 Homicide		mined (Specify)			-	_		or Town, S				, - ,
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Sal					owledge, death occur tion and/or investigat								
To ti comp	Medical	29b. Signature and t		and manner s				ense numb		Tie time, date			Month, Day, Year)	
		, , , ,	1.					C.M.E.	=			5, 2011	ionin, Day, rear)	
	}	30. Name and addre	ess of person	who completed cau	se of death	(Item 23a)			-			,		
		Donna M. Vi	•			. ,	W. Baltimo	re Stree	t, Baltimo	re, MD 21	223			
		31. Date filed (Month	h, Day, Year)	32. R	istrar's Si						<u>-</u>			
Regist	_		JUN 2 '		ensua.		Kel							
DHMH 17 Rev 1/20	001			OCME		ORIGINAL								

11-04321 Michael Vitas Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

VIICIIAE: VILAS	1- For State Registrar State of Maryland / Department of Health and IV Certificate of Death		2. No. 2011 2038
Physician/	Decedent's Name (First, Middle,Last)	Date of Death Month	Day Year 4024 here
Medical Examine	Michael Vitas 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loca	June 8, 201	111 1924 hrs
	3568 S. Hanover Street Baltimore		
Funeral Director	1 M 2 F 44 Yrs. Months Days H	Under 24Hrs. 8. Date of Birth Hours Min. Dec 26	n(MM/DD/YYYY) 9. Birthplace (State or UT) Foreign Country)
ryland a-f show any tronce. ctor	Usual Residence of Decedent 10a. State		1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.		K 10g	g. Citizen of What Country? USA
H		xican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
1215-0036 de filed within 72 hours afte fental Hygiene. sarked nither than "antural", event, the Medical Examines Dee Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk College (1-4 or 5+)		16b. Kind of Business/Industry
21215-0036 ould be filed within 7 I Mental Hygiene. n marked rither than it event, the Medica TO Be Comple		lother's Name (First, Middle, Ma	
	O.C.M.E. 900 W. Baltimo	ore St; Baltimo	ore, MD 21201
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: in State		20c. Location - City or Town, State
	655 W. Balt		imore, MD 21201
Physician /Medical Examiner	23a. Pal I. Enter the disease, in complications that caused the death. Do not enter the mode of dying, such failur. List only one cause on each line. Immediate Cause (Final disease a. Cardia Arrhythmia as consequence of): Due to (or as a consequence of):		Between Onset and
<u></u>	Sequentially list conditions, b.		
60, ate be executed hysician and e burial - transit Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):		
xecuted n and 1 - transit	d. AMENDED 23a,pt.II,27,per me,g916 6	6-28-11 sm	
'60, ate be cabysicia bhysicia			23d. Date of delivery
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit completed by Physician/Medical Ex	23b. Was decedent pregnant in the past 12 months? 1	ctopic pregnancy	Month Day Year
F, P.O. BO; ires that the deat signed by the att the detached for	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Chronic alcoholism; seizure disorder		acco use contribute to the cause of death? 2 No 3 Probably 4 V Unknown
of Vital Records, P.C. 19. Physician: The law requires that ther this certificate has been signed meral director, page 2 should be det. 11. To Be Completed by		24a. Was an autopsy perform	prior to completion of cause of death?
Vital Recysician: The his certificate director, page	25. Was case referred to medical 26. Place of De examiner?	eath (Check only one)	esidence 6 🗸 Other: Scene
C # 2 * 4 5	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at V	Work? 28d. Describe ho	
Division o spiral or Attending tours after death. The spiral or Attending tours after filled in by the function:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building (Specify)	ng, etc. 28f. Location (Stror Town, State	eet and Number or Rural Route Number, City te)
Division of To the Hospital or Attending Physiph 24 hours after death. To the Funeral Director: After a completely filled in by the funeral Medical Certification: T	1 29a. Centiller	th occurred at the time, date an	nd place, and due to the cause(s)
	29b. Signature and title of certifier 29c. License num O.C.M.E.		29d. Date signed <i>(Month, Day</i> , Year) June 9, 2011
	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	re, MD 21223	
State Registrar			
DHMH 17 Rev 1/2001	ORIGINAL ORIGINAL		OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6/24/2011 11:55 A^M Cora Irene White Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carroll Sykesville Brinton Woods If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. Manth 25 / 1922 Country) VA 88 Director 227-44-1163 Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director must be notified 1 Yes 2 K No Westminster MD Carroll 10f. Zip Code 10e, Street and Numbe 10g. Citizen of What Country? ö 23a Funeral 21157 USA 727 Holiday Lane 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after 21215-0036 1 Yes 2XXNo Specify: Specify: White 3 Nidowed 4 Divorced Completed Year or Dates nd Mental Hygiene.

marked other than "natur

matic event, the Medical" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Her Home 6 Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental I permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve once. ည Inda M. Stevenson Grant H. Reedy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2460 Braddock Rd., Mt. Airy, MD 21771 Carol J. Adams/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lawn Mem. Gardens 6/29/2011 Marriottsville, MD f Funeral Service Lices 21. Signar re Burrier-Queen Funeral Home & Crematory, P.A. 212 W. Old Liberty Rd., Winfield, MD 21784 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ToRIUSCUROTIC ne Cause (Final CARDIOVASCUL Physician/ disease or condition) Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury iner Due to (or as a consequence of). Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Honknown of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Division Investigation Accident after deat Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npleted filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature an 29d. Date signed (Month, Day, Year) 127/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Yea SillTe

DHMH 17 Rev 7/2009

State Registrar 2. Registrar's Signature

11-04260 Ва

arry Douglas V	Villia	In Please Type or Print in Black Indelible Ink. Ensure All Copie State of Maryland / Department of Health and Mental H			0.000
,		1- For State Control of Department of Death Registrar	ygierie Reg.		2 . 3
Physici		Decedent's Name (First, Middle,Last)	2. Date of Death	ay Year	3. Time of Death
ledical Exami ॐ⊙₄	ner	Barry Douglas Williams 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	June 6, 201		1606 hrs
0		314 (A) Bourbon Street Havre de Grace	l	Harford	
Funeral		5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	_ `		thplace (State or unk
Director		1 X M 2 F 67 Yrs. Months Days Hours Min.	Nov 1, 1	.942 Foreig	untry)
su s		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ļ	MD Harford Havre de Grace			1 Yes 2 No
farylar 28a-f s Laton	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cour	ntry?
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and hennel Hygie weith and Manal Hygie with the "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once		314A Bourbon Street 21078		USA	
ath wit	Funeral	11. Marital Status UNK 1 Never Married 2 Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 14. Was Decedent of Hispanic Origin?)		14. Race - Amer White, etc.	can Indian, Black,
her de:		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify:		Specify: bla	ick
ours at atura	d by	15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of violation proof of wedling life, PO NOT up a still	work done unk 16		
36 in 72 h han "n ical E	pleted	Elementary/Secondary (0-12) College (1-4 or 5+)			_
5-0036 led within 72 Hygiene. I other than the Medical	Compl	12 unik 0 unik file clerk 17. Father's Name (First, Middle, Last) unik 18. Mother's Name		banking ir den Surname) und	
ID 21215-0036 should be filed within 77 and Mental Hygiene. 77 is marked other than matic event, the Medical	Be (Talley H. Williams Franc	es Hammi	ρ	
21 Should and Me is ma	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	Rural Route Numbe	r, City or Town, State	G-1110
imore, MD Pages 1 and 2 sho ment of Health and lant: If item 27 is or other traumati		Lisa Williams - sister 119 E.19th St. Apt 1F 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.		n, New Yor	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place)		oo. 2000.ion Only of	Tomi, date
Baltimore permit. Pages 1 Department of H Important: If it	1	4 Donation 5 X other Specify: in state 21 Signa e of neral ryice Licensee de, Dir tor 22. Name and Address of Facility St	ate Anat	omy Board	-
E P P W		Acceptable 1 655 W. Baltimore	St: Balt	imore, MD	21201
Physician /Medical	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. <u>Hypertensive Atherosclerotic Cardiov</u> Due to (or as a consequence of):	ascular 1	Disease	Death
		Sequentially list conditions, b			
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Clipsopare in interest is interest.			
d d	Examiner	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):			
executed an and al - transit		d. ☑ UNPENDED ☑ AMENDED.Items# 15.16a-b.17.18.19a-b.23a	t TT 0	7	
	Physician/Medical	■ MENDED Ttems # 15,16a-b,17,18,19a-b,23 IF FEMALE: 23c If yes, outcome of pregnancy 23c If yes, outcome of	a,pt.11,2	23d. Date of delivery	
lox 68760, leath certificate be attending physici for use as the buri	an/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregna	incy		Day Year
Box 68760 e death certificate b the attending physi	ysici	4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
. ĕ Ţĕ		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
s, P.O nires that to signed by d be detac	d by	Diabetes Mellitus	1 Yes	2 No 3 Prob	ably 4 🗹 Unknown
cords law requi	plet		24a. Was an autopsy	prior to o	topsy findings available completion of cause of
Rec The la icate h:	Completed		performe	ed? death? ☑No 1 ✔ Ye	s 2 No
Vital Recyysician: The this certificate director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Innation: 2 FB/Outpatient 3 DOA Others Nursing			
	<u>유</u>	examiner/ 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other,4 Nursin 27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work?	g Home 5 Re 28d. Describe how	sidence 6 🗹 Other	: Scene
ion of tending Pheath. tor: After the funeral	Certification:	Natural 5 Pending 1 Yes 2 No		, ,	
ViSi or Att of Att of Att of Att	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street or Town, State		ral Route Number, City
Division Hospital or Attence 24 hours after death Funeral Director: tely filled in by the	Cer	determined (Specify) 29a. Certifier () Constant Physics Talks () Constant Physics () Cons		<u> </u>	
	Medical	293. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
To the within To the comple	Med	29b. Signature and title of certifier 29c. License number		9d. Date signed (Moi	
		O.C.M.E.	J	lune 7, 2011	
		30. Name and address of person who completed cause of death (Item 23a)			
		Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltim 31. Date filed (Month, Day, Year) 32 Registrar's Signature	nore, MD 2122	3	
	-17.1	on paro mod (would). Day, reall Ozarlogistics Signature			

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time Weath MILDRED ASSER MAN 4a. Facility Name (if not institution, give street and number 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 K F Days Min. Hours 0171171925 Country) 217-14-2748 86 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No BALTIMORE RANDALLSTOWN 10e. Street and Number 10g. Citizen of What Country? 3934 CHAFFEY ROAD USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 BOOKKEEPER GIFT SHOP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES FRANK **JENNIE** COHEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL WASSERMAN/SON 377 ROCKLAND ROAD, WESTMINSTER, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State NESSETH ISRAEL NSHE KOLK CEMETERY 06/23/2011 4 Donation 5 Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Line SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final neumon disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) Month Pregnant at time of death Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician/ Medical **Examiner**

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attending physician for use as the buria

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page 2 should

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Completed

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Certificate:

Medical

The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

the Hospital or Attending Physician:

Physician/

Examiner

Funeral

Director

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23a

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should be file and Mental F is marked o

Department of Health ar Important: If item 27 is any injury or any

72 hours after death

Maryland 21215-0036

Baltimore,

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Medical Examiner must be

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MD

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami resulting in death) Last Physician/Medical

23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

1 \square Yes 2 \square No 3 \square Probably 4 Unknown 24a. Was an

26. Place of Death (Check only one) Hospital Other:

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

iniury

24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No Yes 2 No 1 Yes

examiner? 1 Yes 2 No
27. Manner of Death
1 № Natural 5 🗆 Pendir

2 Accident

(Check

only one)

28a. Date of injury (Month, Day, Year) 5 Pending Investigation

1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28c. Injury at 28d. Describe how injury occurred work?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \)

28f. Location (Street and Number or Rural Route Number,

	Homicia		determ		
202	Certifier	1 🗸	Cortifuino	Dhys	

Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of	certifier		
1/1/11	17	1	Mos
- any	9-01		(, ()

29c. License number

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 21^{Day} Virginia Witkowski June 2ď11 7:45 PM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 604 Priestford Road Churchville Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2**X** F Hours Maryland 8/2/1920 218-14-5985 90 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Harford 1 Yes 2 No Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 604 Priestford Rd. 21028 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo 1 Never Married 2 Married If Yes, Give Year or Dates Specify: White 1 ☐ Yes 2 X No Specify. 3X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clerk 0 Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elihu Roland Etta Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Witkowski / Son 40 Cadwell Crt. Conowingo, MD 21918 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Churchville Pres.Cem. 6/24/2011 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Churchville 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P
333 S. Parke St., Aberdeen, MD Funeral Service Lice ee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death rosepsi disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Pregnant at time of death

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Physician/ , Medical Examiner

Physician/

Medical

Director

Funeral

2

Completed

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Sign

29b. Signature and title of certific

REVIN

30. Name and address of persen who completed cause of death (Item 23a) (Type, Print)

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

and Mental Hygie is marked other

Important if item 27 is:

Page 1

Maryland

Baltimore,

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attending physician and for use as the burial-trans signed by the a within 24 hours after death

To the Funeral Director: /

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events resulting in death) Last Physician/Medical 23b. Was decedent pregnant in the past 12 months?
1 Pyes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending injury Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Urgini A Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND TIEM#18perFH, G916,6/30/2011, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Julia A. Zawitoski 1:50 P M June 16, Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Gilchrist Hospice Towson Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 TXF Days Jul. 7, 1930 Hours 218-28-0624 80 Washington DC Director Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a State filed within 72 hours after death with the Maryland Director notified 1 🗆 Yes 2 No Sykesville Carrol1 0 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country?
United States be 1 21784 Funeral 23a 7229 Caracara Court items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc o, þ 1 Never Married 2 Married 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be (Baltimore, Maryland 18. Mother's Name /First Middle Maiden Surname)
Mamie Whittington - Woodington 17. Father's Name (First, Middle, Last) ပ William Wise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7229 Caracara Ct., Sykesville, MD 21784 19a. informant's Name/Relationship (Type, Print) Kathleen Dorsey - Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gleeneten repeatory or other place)
Memorial Park ☑ Buria 2 ☐ Cremation 3 ☐ Removal from State 6-21-2011 Glen Burnie, MD ☐ Don: on 5 C Other (Specify) r I Service Licensee Name and Address of Facility Ambrose Funeral Home, Sign 1328 Sulphur Spring Rd., Arbvutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between METASTATICOVARIANCANCOR Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading loan module cause. Enter Underlying Cause (Disease or iinjury Examiner que to for as a nonsequenne offi Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month Yes 2 g Unknown a \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ATRIAL FIBRILLATION Records, 1 Yes 2 No 3 Probably 4 Onknown POLYCYTHEMIA VERA 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one, Hospital Other: <u>ا</u> 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 24 hours after death. Funeral Director: A: Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical 29a. Certifier 1. Decritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 only one) 29b. Signature and title of certifie 2

Registrar

State

31. Date

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6701 NORTH CHARLES STREET BALTHUREMIL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Anton Demichael A	1- For State	State of Maryla		ment of I		d Mental		Page No. 20	11 2039
Physician Medical Examine							2. Date of De Month	Day Year	3. Time of Death 2338 hrs
medical Examine	4a. Facility Name (if not in	stitution, give street and nu	mber)	1	City, Town, or	Location of De	June 7, 2	4c. County of	Death
Funeral	1411 Bald Eagle 5. Social Security Number		7. Age (In yrs. last b		Oxon Hill If Under 1 Year	r If Under 24	Hrs. 8. Date of I	Prince Ge	eorge's 9. Birthplace (State or
Director	577-06-742		43	Yrs.	Months Days				Foreign DC
áu a	Usual Residence of Deceding 10a. State 10b. C		10c. City, Tow	vn or Location					10d. Inside City Limits
land f show :	MD Pr:	ince George's	Distri	ict Hei	lghts				1 X Yes 2 No
the Maryland n or 28a-f sh tifled at once Director	10e. Street and Number	Drive		1	Of. Zip Code 20747			10g. Citizen of What United St	•
n with the mas 23a be noti		12. Was Dece	edent Ever in U.S.		Decedent of His		(Specify Yes or Nerto Rican, etc.)	lo- 14. Race -	American Indian, Black,
ter death with ", or items 23 er must, be no		Married 1 Yes Divorced If Yes, Give Yeer	2 No		es 2 X No		arto Ricari, etc.)	White,	Black
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		l or Dates: n (Specify only highest grad	e completed) 16a	a. Decedent's	Usual Occupation	ion (Give kind		16b. Kind of Busi	ness/Industry
5-0036 ed within 72 hour it giene. other than "natu the Medical Exan Completed	Elementary/Secondary ((0-12) College (1-	-4 or 5+)		reneur	501101 400	romouy	Private	e
MD 21215-0036 ad 2 should be filed within 7 thth and Mental Hygiene. m 27 is marked other than anumatic event, the Medical	17. Father's Name (First, M	Middle, Last)						, Maiden Surname)	·
2121 ould be fil d Mental H s marked tie event,	Calvin Agui		- 1	9b. Mailing A	ddress (Street	Zola F and Number		umber, City or Town,	State, Zip Code)
MD 2 sho salth and 2 sho salth and 27 is raumat	Alethea Agu	urs/ Wife			ould Dr		rict He	ights, MD	20747 City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	1 X Burial 2 Cre	mation 3 Removal fro	m State crema	atory or other Linco	place)		5/16/201		
Saltin rmit. P epartme nportau jury or	4 Donation 5 Ott 21. Signature of Funeral S						•	ral Homes	
Physician	23a. Part I. Enter the disea	se, or complications that ca	used the death. Do i					stville, I	
/Medical	failure. List only one Immediate Cause (Final di	sease a. Multiple Gur	nshot Wounds						Between Onset and Death
Same and the same of the same and the same a	or condition resulting in de	b add to (or up a	consequence of):						
ted Insit	if any, leading to immediat cause. Enter Underlying C (Disease or injury that initial	e Due to (or as a cause	consequence of);				·		
uted d ansit	events resulting in death)		consequence of):						
be executed sician and unial - transit	UNPENDED	AMENDED							
Division of Vital Records, P.O. Box 68760, at or Attending Physician: The law requires that the death certificate b its after death. a) Director: After this certificate has been signed by the attending physical in by the funeral director, page 2 should be detached for use as the burstification: To Be Completed by Physician/Mee	IF FEMALE: 23b. Was decedent pregnar past 12 months?	23c. If yes, o	utcome of pregnancy	y 2 Fetal	death 3	Ectopic pre	gnancy	23d, Date of de Month	elivery Day Year
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me	1 Yes 2 No 9	Unknown 9 Unknow	nt at time of death	5 Other	(Specify)				
Vital Records, P.O. By yician: The law requires that the de his certificate has been signed by the director, page 2 should be detached on Be Completed by Phy		conditions contributing to	death but not resulti	ng in the unde	erlying cause gi	ven in Part I.			ute to the cause of death?
ds, Pequires 1 een sign ould be c							1Ye		Probably 4 Unknown
Records, The law requires fricate has been sig				· · · · · · · · · · · · · · · · · · ·				ormed? dea	or to completion of cause of ath? Yes 2 No
ital Reco	25. Was case referred to mexaminer?	Hospital:				of Death (Che	ck only one)		
of Vina Physical Phys	1 Yes 2 No	28a. Date o	f Injury 28b.	Outpatient 3 . Time of Injur		Other Nur at Work?		Residence 6	
Division of ' bivision of ' pital or Attending Ph iours after death. oral Director: After t filled in by the funeral Certification: T	The state of the s								
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Division To the Hospital or Attend within 24 hours after death To the Fooeral Director: completely filled in by the	29a Centiler	ing Physician: To the best							
To the He within 24 To the Fe completed	29b. Signature and title of o	and manner sta			29c. License				(Month, Day, Year)
	my l	w. v.			O.C.N	1.E.		June 8, 2011	
R5		erson who completed cause sistant Medical Exam	, ,		Street, Balti	more, MD	21223		
State Registrar	31. Date filed (Month, Day,	Year) 32. Reg	istrans Signature	الما					•

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2<u>011</u> June 11, Physician/ Thomas Stewart Ashton, Jr. 4:35 p^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice-Casey House Rockville Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F Min. Months Hours 218-84-5841 $March^{Month, Day} 1^{Year} 1962$ 49 Director D.C. Usual Residence of Decedent 28a-f show 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Montgomery Gaithersburg 1 Yes 2 No ò 10e. Street and Number 10g. Citizen of What Country? , or items 23a Funeral 166 Crossbow Lane 20878 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Giv Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: Specify: White "natural", 3 Divorced 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Architectural Draftsman Architecture Be filed 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hi Important: If item 27 is marked otl any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Stewart Ashton Naomi Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi Ashton/Mother 13406 Lydia Street, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 KPBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, June 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 2011 Silver Spring, MD 21. Signature of Funeral Service Licenses Francis Adress Corinins Funeral Home Inc. 00 University Blvd. W., Silver Spring, MD 20901 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1 Immediate Cause (Final Onset and Death Squamous Cell Carcinoma of Left Frontal and Ethmoid Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence or, cause. Enter Underlying that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 SB IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy signed by the atte in the past 12 months? Day Year Pregnant at time of death Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician; The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has performed? After this certificate 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospice Hospital 2 🛛 No Other: ၉ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniurv work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation М Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1355

egistrar's Signatur

MD

Bindu Joseph,

31. Date filed (Month Car)

D60634

Piccard Drive, #100, Rockville, MD 20850

June 12, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6 Day JUNE NEIL DAVID BISHOP 201°1 10:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death QUEEN ANNE S Examiner 4b. City, Town, or Location of Death 5014 BRIDGEPOINTE DRIVE CHESTER 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1**X** M 2 □ F APRIL 25, 1920 389-16-0698 WISCONSIN **Director** 91 Yrs Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND QUEEN ANNE'S CHESTER 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5014 BRIDGEPOINTE DRIVE 21619 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 X Yes 2 \(\square\) No **1941-**Black, White, etc. Š 1 Never Married 2X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural" Completed Specify: WHITE 3 Divorced 4 Divorced 1946 permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE Elementary/Seconday (0-12) College (1-4 or 5+) MUSICIAN SYMPHONY ORCHESTRA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DAVID CHARLES BISHOP FLORENCE MAY UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEFFREY BISHOP / SON 1504 CALVERT ROAD, CHESTER, MD 21619 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State CROWNSY ILLE VETERANS CEMETERY 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 06/13/2011 CROWNSVILLE, MD Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition resulting in death) MELANOMA METASTATIC MELLEN Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury and the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No
9 Unknown Pregnant at time of death Month Day Year 9 🗌 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by TRACT INRECTION 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? NSTHMA 24a. Was an has page 2 autopsy perform After this certificate 1 ☐ Yes 2 ☐ No after death.

Director: After this certifical in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: ပ္ 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours eted filled Medical Lacertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) and ad ress of person who completed cause of death (Item 23a) (Type, Print) STEVENSMUE, MO m DRIVE JAMIE HALMS SALLITY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN - 9 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2104 M Buckner, Sr. Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** 4b. City, Town, or Location of Death res rance Social Security Number If Under 1 Year | If Under 24 Mrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 1 ፟ M 2 ☐ F Days Hours Min. (Month, Day, Year) 06/12/1945 MD **Director** 213-44-2678 65 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Capitol Heights 1X Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral United States 1002 Balsamtree Drive 20743 72 hours after death "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Private Self Employed Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lottie Proctor James Buckner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8717 Contee Road, Laurel, MD 20708 Shawnee Y. Buckner/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory 6/10/2011 Riverdale, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20747 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ EXSANGCINATION disease or condition resulting in death) Medical consequence of) Examiner omplications Ecquentially not according to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physiclar Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examine ? Hospital 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Spe 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred to the constraint of the constra 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending June 7, 2011 2/04 M 1 Yes 2 No Investigation 28f. Location (Street and Number or Rural Route Number, Dr. Citror Town. State) 2001 405 2001 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital MANGAR Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nursa Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nursa Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6/48/0 3001 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:36 PM **Bam** Gregory Medical 2011 June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery #538 1801 East Jefferson Street Rockville 5. Social Security Number 8. Date of Birth (Month, Day, Year) Aug. 10,1917 If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Min. Months Hours 1 🔀 M 2 🗆 F Russia Director 105-24-4056 93 Aug. Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Montgomery Rockville 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1801 East Jefferson Street #538 20852 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 0. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 Tes 2 No Specify: Hygiene. 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours pepartment of health and Mental Hygelen. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry Photo Camera and (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Equipment Repair Co. Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Kilman Anna Gilel Bam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheryl Shapiro/Grandaughter 11713 Dinwiddle Drive, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 7 Geo Wash University 1 Burial 2 Cremation 3 Removal from State Medical Center Washington, D.C. 4 X Donation 5 ☐ Other (Specify) 2011 22. Name and Address of Facility Columbia Mortuary Services, P.A. Signature of Funeral Service Licensee /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Metastatic Sarcoma Of The Scrotum 6 Months disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy Dav Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed?
☐ Yes 2 🔀 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Division of Vital Hospital: Other: 2X No ဥ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred injury 1X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A
completed filled in by the fu 1 Yes 2 No Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatu title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D035045 June 13, 2011 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe 18109 Prince Philip Drive Suite 200 Philip Henjum, M.D. Olney, MD 20832 31. Date filed (Month State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Wilmo obert Sr. 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Peath HIGMIC 19/ONAL Mediase 584/50414 If Under 1 Year If Under 24 Ars. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Min (Month, Day, 220-34-9215 Director Mary land Jan. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Princess 1 X Yes 2 ☐ No Maryland Somerse 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 30589 Circle 21853 U.S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify: If Yes, Give Year or Dates Black and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Univ. of Md. Eastern Share Supervisor Grounds Coth grade injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Baile B. John Sr. Shelton Dorothi permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn 11979 Ln Princess Anne, md, 21853 Marshall 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 1 Burial 2 Cremation 3 Removal from State 18/11 Venton, mD 4 ☐ Donation 5 ☐ Other (Specify) Grace U.M.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ward any 9 woul 30639 Princess Anne, MD. Hampden 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ EA MONA CEL disease or condition) Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): -transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day 1 Yes 2 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 N 1 Yes l or Attending Physician: after death. 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 1 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 V Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No Investigation 1 Yes Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital o within 24 hours af To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

SALISBURY MD2/804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:07 M AINE MAVNIARN CUE 2011 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Columbia Howard Howard County General Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 24 Hrs. 1 Year 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 04-08-1944 225 60 2731 67 unknown Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 5431 Tilted Stone 21045 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 22 No
If Yes, Give þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: White 3 ₺ Widowed 4 □ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Social Security 1 and 2 should be filed within 72 fealth and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Administration unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Maynard Loretta Belanger other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 511 Farm Street New Bedford, Massachusettes 02740 Donna Marie Bolduc/God Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Page 1 ò 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, injury o 4 Donation 5 Other (Specify) Ardent Cremation Svc. 6-14-2011 Hanover, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. allows 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEATIC Physician SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CHEMIC Sequentially list conditions, if any, leaving to increase cause. Enter Underlying Examine burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year g ☐ Unknown 9 Unknown Division of Vital Records, P.O. as been signed by 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page performed? Yes 2 funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: |요 1 Impatient ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending after death.

I Director: After in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F Jint 12, 2011

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HO ARM IRY

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June ^{Day} 2011 12. 12:15 PM Ung Sang Cho Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Clarksville Howard 6022 Signal Flame Court Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country).
Korea **Funeral** Feb 3, 1932 1 🔀 M 2 🗆 F Hours Director Yrs. 159-52-5638 79 Usual Residence of Decedent 28a-f shov 10b. County notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 v No MD Howard Clarksville 10e. Street and Number ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral with 6022 Signal Flame Court 21029 United States death ' 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Completed 3 Widowed 4 Divorced Specify. Asian Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry Je filed wm. Tatal Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other that any injury or other transment. Convenience Store Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Byung Tae Cho unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myung O. Kim/Daughter 10408 Wetherburn Rd. Woodstock, MD 21163 Baltimore, 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Crest Lawn Cemetery 6/15/2011 Marriottsville, MD 22. Name and Address of Facilit Harry H. Witzke's Family, F.H.Inc 21. Signature of Funeral Service Licensee Collis-4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Opset and Death Immediate Cause (Final Ph. sician disease or condition Medical resulting in death) Due to (or as a conse **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Exami that the death certificate be executed and trar Due to (or as a consequence of): resulting in death) Last g physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has autopsv death? certificate 2 No 1 Yes 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Kesidence 6 Other (Specify hours after death. uneral Director: After this of filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours Funeral leted filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 within 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mueno D54413 June 14, 2011

State Registrar 31. Date filed (Month)

Knol

North DR. 5.140 Columbia

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5450

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11 Day June 2011 6:50 A M Eleanor Mary Corbett Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10764 Frederick Road Ellicott City Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Feb 20, 1928 1 M M F Hours Minnesota **Director** 470-26-4164 83 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No MD Ellicott City Howard 5 10e, Street and Number 10g. Citizen of What Country? 23a 10764 Frederick Road 21042 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed ¥☐ Widowed 4 ☐ Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Secretary University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H 2 John Melink Cecelia Bordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health .0764 Frederick Road Ellicott City, Maryland 21042 Kellie Morstein/Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important; If ite any injury or ot Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Ceme. 6/15/2011 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service License Thomas uanta K M00957 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Dement disease or condition resulting in death) nonth Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): and -transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical that the death certificate be as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ (OPD end Stage 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 🗌 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Natural
Accident
Suicide
Homicide (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certifier D005315C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Santicpo epte 965 State Registrar

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, Las	st)		illicate of L	Jeani	2. Date of Dea	Reg. No.		
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	Funeral		5. Social Security Number 6. S	Sex 7. A	Age (In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		9. B	irthplace (State or Foreign ountry) VA	
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	nd how at	or	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits	
	laryla 3a-f s iified	Director	MD Mont	gomery	Silver	Spring				1 Yes 2 🗷 No	
	or 28		10e. Street and Number	8		10f. Zip Code		T	10g. Citizen of What C	ountry?	
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Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	1	19a. Informant's Name/Relationship (7) Lucie Smith/Gran		19b. Ma 512	ling Address (S <i>treet a</i> West Main	and Number or Ru Street,	ral Route Number M1ddlet	Oity or Town, State, 2 Own, MD 21	769	
re,	1 and of Hea item	- 3	20a. Method of Disposition	-	20b. Place of Disp	osition (Name of	- I	Date 1 /	20c. Location - City of	or Town, State	
⊏	Page 1 ment of lant: If its		1 ☐ Burial ※⊠ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		te Metropoli	ematory or other place tan Crema	tory Ju	ne 14, 2011	Alexandria	, VA	
Baltimore,	permit. Page 1 Department of Important: If i any injury or o		21. Signature of Funeral Service Licens	see	_ !	2. Name and Address Trancis J. 00 Univer	Çollins Çollins sity Blv	Funeral	Home Inc.	.ng,MD 20901	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State Registra Amend #17. Per FHPGC 6-14-11cr Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MO06/09/2011 6:15A M Augusta B. Greenwald Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery 5555 Friendship Blvd.#213 Chevy Chase Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Days Hours 02%TOPY923 New York, NY **Director** 88 100 16 4863 Usual Residence of Decedent or 28a-f show 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 20815 United States 5555 Friendship Blvd. #213 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mea gnoe. Elementary/Seconday (0-12) College (1-4 or 5+) Education School Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jacob Berlfein Jacob Belfein Rose Stern 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randi Greenwald/Daughter 94-4 Park St. Portland, Maine 04101 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State National Crematory Falls Church, VA 4 Donation 5 Other (Specify) 06/15/2011 22. Name and Address of Facility Joseph Gawler's Sons, Inc. Signature of Funeral Service Licensee Washington, DC 20016 5130 Wisconsin Ave., NW lu 23a. Part 1. Enter the clease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final and Death Physician/ Months disease or condition resulting in death) Failure to Thrive Medical Due to (or as a consequence of) Examiner Years <u>Dementia of Alzheimer's Type</u> Sequentially list conditions, Examine Dire to (or as a consequence of) cause. Enter Underlying To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetes Mellitus, Hypertension, Depression Completed 1 Yes 2 XNo 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 😿 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No 4 Nursing Home 5 Residence 6 Other Specify Other: 은 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npleted (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and time of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53376 06/09/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Rajan Shyamsundar 9801 Georgia Ave., #117 Silver Spring, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Da

JUN 1 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June Day 2011 Year 1:32 11, p_M Elmer L. Greenfield Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Jan 3, 19721 Birthplace (State or Foreign Country) MD 7. Age (In vrs. last birthday) **Funeral** 1 🖾 M 2 🗆 F 214-18-8270 90 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director MD Silver Spring Montgomery 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be Funeral 20902 with items 23a 2911 Kingswell Drive death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Was Decedent Ever Armed Forces? 1 XYes 2 No Black, White, etc ō ģ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 A No Specify: Specify: White WWII "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunications Engineer Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic even ဂ္ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic John L. Greenfield Annie M. Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Greenfield/Son 19938 Appledowre Circle, Germantown, MD 20876 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State June 1 2011 Parklawn Memorial Park Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, Md 20901 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sici n Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of). **Examiner** Acute Blood Loss Anemia Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury -transit the Hospital or Attending Physician: The law requires that the death certificate be executed Bleeding Abdominal Aortic Aneurysm and that initiated events Due to (or as a consequence of): resulting in death) Last the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IE EEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Hunknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page certificate 2 No 1 Tyes 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner?

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifging Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one 29b. Signature and title of icense number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

d address of person who co

31. Date filed (Mo.

ppleted cause of death (Item 23a) (Type, Print)

gistrar's Signature

and

11-04493 Ira Gray, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are	Legible.				
State of Maryland / Department of Health and Mental Hygiene	2	01	per remain h	2040	
Certificate of Death	Reg. No.				

		- For State Cer	tificate of	Death		_ R	leg. No.		
Physicia		. Decedent's Name (First, Middle,Last)			Date of Dea Month	ath Day Year	3. Time of Death		
ledical Examin	er	Ira Bernard Gray	Jr.			June 15,		0633 hrs	
		a. Facility Name (if not institution, give street and number)	4	b. City, Town, or Lo	ocation of Deat	1	4c. County of	Death	
/		Holy Cross Hospital		Silver Spring			Montgom	ery	
Funeral	┱	5. Social Security Number 6. Sex 7. Age (In yrs. Ia	ast birthday)	If Under 1 Year	If Under 24Hr	s. 8. Date of Bi	rth(MM/DD/YYYY)		
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laryland	휘			10f. Zip Code			10g. Citizen of Wha	at Country?	
Mary 28s	Director	10e. Street and Number 1128 Pearl Street		152	221		USA		
3a o		1120 Peall Street							
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after II", o	ᇗ	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 X No			Specify:		
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72 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		-			Coll	000	
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21215-0036 uld be filed within 7 Mental Hygiene, marked other than cevent, the Medica	å	Ira Bernard Gray Sr.			Patri	cia Ar	lene St	ubbs	
ID 21215-00; should be filed with and Mental Hygiene. 7 is marked other that and marked other that the Med.		19a. Informant's Name/Relationship (Type, Print)	Rural Route Nu	mber, City or Town	, State, Zip Code)				
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ore, M es 1 and 2 of Health If item 2 her trans	ď			tion (Name of cem	etery,	Date 21/201	20c. Location -	City or Town, State	
Baltimore, MD 21215-0036 bemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fah. Injury or other tranmatic event, the Medical Examiner must be notified at once		T A Buildi 2 Cremation 9 K Removal from State	rematory or oth	ny Cemet		21/201		burgh, Pa.	
ti. Pr	- }	4 Donation 5 Other Specify: A L 21. Sign - se of Funeral Servi / Li ens				D.T. 131131			
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	- 1	or condition resulting in death) Due to (or as a consequence o	1).						
	<u>=</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence or	f):						
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Si O After A deal deal	ఠ	2 Accident Investigation Fd 6-15-11 28e. Place of Injury - At h	fd 5:30	am et factory office bu	uilding etc.	28f. Location	(Street and Number	er or Rural Route Number, City	
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1-90	å S	29b. Signature and title of certifier	1.0						
		fluster of	11/1	O.C.N	/1.⊏.		June 16, 20		
		30. Name and address of person who completed asse of death (Item					4000		
		Russell Alexander MD. Assistant Medical Exan		W. Baltimore	Street, Balti	more, MD 2	1223		
	ate	31. Date filed (Month, Day, Year) 22. Registrar's Signature 22. Registrar's Signature 23.	ure Mark	1	00	ME			
Regist	rar	JUN 2 1 2011 Sener B.	7						

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	for State Registrar		Maryland /	•	rtment of F tificate of E		and iv	/lental Hy	giene Reg. No.	2011	20404	
Physician/	1. Decedent's Name (First, Middle ARTHUR DWIGHT							2. Date of De Month JUNE	eath Day	Year 2011	3. Time of Death 11:00 A ^M	
Medical Examiner	4a. Facility Name (if not institution 109 FRIENDSHI	_	r)		4b. City, Town, or CENTR		JONE	4c. C	County of Dea			
Funeral Director	5. Social Security Number 217–38–6412 Usual Residence of Decedent	1 🕅 M 2 □ E	Age (In yrs. last b		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da MAY 23	th ay, Year) 1941	9. Bir	rthplace (State or Foreign ountry) MARYLAND	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 🛣 Mar 3 □ Widowed 4 □ Divorcec	12. Was Deceder Armed Force ried 1 1 1 Yes 2	s? □ No	lf 1	as Decedent of Hi Yes, specify Cubar	n, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14	USA 4. Race - Ame Black, White	te, etc.	
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should and Me is marl raumati	19a. Informant's Name/Relations	hip (Type, Print)		_	Address (Street a	and Numbe	r or Rura	al Route Numbe	er, City or To		•	
1 and 2 of Health item 27 other to	MARILYN HOOP 20a. Method of Disposition		20b. Place	e of Dispos	RIENDSHI	- 1		CENTRE Date			r Town, State	
tt. Page rtment c rtant: If njury or	1 Bunal 2 Tremation 4 Donation 5 Other (5	Specify)	CHESA CENTE	R	CREMATI		UNE 2011				ILLE, MD	
Dermi Depa Impo any it	21. Signature of Funeral Service I	Hellen	ein	FEI 408	Name and Addres LOWS, HE S. LIBE	LFENI RTY S	EIN	& NEWN CENTRE	AM FU	NERAL , MD 2	HOME, P.A. 21617	
Physician/ Medical Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	only one cause on each		OER		g, such as			rrest,		Approximate Interval Between Onset and Death	
ecuted and I-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	b. — Due to (or a	as a consequenc	ce of):								
physician ar the burial-tr edical Ex	resulting in death) Last	ce of):										
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Medical Certificate: To Be Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 🗌 Fetal de t at time of deatl	eath 3 🗌	Ectopic pregnanc Other (specify)	у			23	3d. Date of de Month	elivery Day Year	
quires that the signed by the detail the det	Part II. Other significant condition	ons contributing to deat	h but not resultin	ng in the un	derlying cause giv	en in Part I		23e. Did t	~	/ _	o the cause of death? Probably 4 🗌 Unknown	
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hysician: nis certific I director, To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	atient 2 ER/	/Outpatient	Othe	er:		k o <i>nly one)</i> ome 5 ∑ Resi	dence 6	Other /Spec	Cify)	
or Attending Phy after death. Director: After thi I in by the funeral (Certificate: T	27. Manuer of Death 1 Natural 5 Pendir 2 Accident Investi	28a. Date of in (Month, in gation		b. Time of injury	28c. Injury work	at at		28d. Describe I			5.1.y	
oital or Att urs after deral Directu illed in by t	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 28e. Place of building,	Injury - At home, etc. (Specify)					City or Tov	(Street and Number or Rural Route Number, wn, State)			
he Hospital in 24 hours he Funeral ipleted filled	(Check 2 Medical E	Physician: To the best xaminer: On the basis of Nurse Practioner: To t	f examination and	d/or investig	gation, in my opinio	n, death oc	curred at	the time, date a	and place, a	nd due to the	cause(s) and manner stated.	
	29b. Signature and title of ceptified	Swr			29c. License	number 398	8-	1		signed (Mont	th, Day, Year)	
Det Det	30. Name and address of person DAVID H. SMITH					301,	EAS'	ron, MD	2160	1		
State Registrar	31. Date filed (Month, Day, Year)		rar's Signature									

State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 30, 2011 Anna Maye Hurley 1425 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Takoma Park Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔻 F Months Days Hours Min. Sept. Z, 1925 578-30-5130 Raleigh, NC Director 85 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No DC N/A Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1335 Shepherd Street, NE 20017 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces 2 Black, White, etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Negro If Yes, Give Year or Dates 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7, Department of Health and Mental Hygiene. Important. If item 27 is marked other than any injury or other traumatic access. College (1-4 or 5+) Elementary/Seconday (0-12) Director, Mental Health Psychiatric Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Daniel Lott Smith Martha Jane Rogers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellard-James Hurley /Son 1335 Shepherd St., NE Washington, D.C. 20017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Maryland National 06/09/2011 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Acensee 22. Name and Address of Facility McGuire Funeral Service, 7400 Georgia Avenue, N.W. Washington, DC 20012 23a. Patt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final hevoscleroke Cardiovuscular disen Ph_sician/ disease or condition) Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to in mediate cause. Enter Underlying Dee to for se's consequence on and I-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 Ne 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 No Other: 1 Tyes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 🗹 🇲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05-30-11 MD 00060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVD San Silver State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death [□]2011 **Physician** June 8, Katherine B. Hunter 0214 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Fort Washington Medical Center Fort Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🖾 F Director 94 North Carolina <u>244-03-</u>1623 May 10, 1917 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County Show a or 28a-f show t be notified at 10d. Inside City Limits Directo Accokeek 1 X Yes 2 □ No Maryland | Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or Items 23a Examiner must b 15300 Cedar Drive 20607 permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23 any Injury or other traumatic event, the Medical Examiner must Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 Ho Specify: λq Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gecrge Barnes Shula Morrison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest R. Hunter - Son 4804 Jefferson Street Lanham, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June $\overset{\scriptscriptstyle{\mathsf{Date}}}{\mathsf{15}}$. 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Washington National 2011 Suitland, Maryland 21. Signature of Funeral Service Licensie Stewart Funeral Home, 4001 Benning Road NE Washington, DC 23a Part. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Doath uch as cardiac or respiratory arrest, Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit and Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __ ō in the past 12 months? 1☐ Yes 2 No Month 4□Pregnant at time of death Day Year 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy perforn To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation Injury

The law requires that the death certificate be executed Records, P.O. Box 68760, attending physician the ģ signed t certificate Division or Vital

Baltimore, Maryland 21215-0036

2 Accident 6 Could not be determined 3 ☐ Suicide

4 ☐ Homicide

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11711 Livingston Road Amir Mirza-Alikhani

Fort Washington, Maryland

State Registrar

31. Date filed (Month, Day **JUN 1 4**

Medical

			for State Registrar		State of	Marylar		artment <i>tificate</i>			Mental H	ygien Reg. N	201		204	17
	- DI		Decedent's Name (First)	, Middle, Las	st)						2. Date of D	eath		•	3. Time of De	ath
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	Exami	ner	4a. Facility Name (if not in:			er)		1	wn, or Loca ever1	ation of Death		4	Ic. County of D		1-	
Alba Ar	Funeral		2803 Cheve 5. Social Security Number			Age (In yrs. I	last birthday)	If Under 1		y Jnder 24 Hrs.	8. Date of B	irth	Prince		ace (State or Fe	oreian
	Director		220-32-661	0 1	□ M 2 🖾 F	93	Yrs.	Months E	Days Ho	ours Min.	(Month, December	pay, Year,	1917 Ba	Counti 1 t i n	ore, Mar	y la r
	nd how at	٦	Usual Residence of Deced 10a, State 10b.	dent County		10c Cit	ty. Town or Lo	cation						10	d. Inside City L	imite
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	r deat or iten iner r	by Fu	11. Marital Status 1 ☐ Never Married 2	Marriad	12. Was Decedent Ever in U.S. Armed Forces?			Was Decedent f Yes, specify	t of Hispani Cuban, Me	ic Origin? (Sp exican, Puerto	ecify Yes or No Rican, etc.))-	14. Race - A Black, W			
21215-0036	ral", c	q pa	3 X Widowed 4 🗆 D		If Yes, Give Year or Date	1 ☐ Yes 2 ☒ No If Yes, Give 1 Year or Dates			No Sp	ecify:			Specify: W	hit	e	
	2 hour	plet	15. I (Specify on	Decedent's E	ducation ade completed)		16a. Deced	lent's Usual C	ocupation	most of work	rina	16b.	Kind of Busine	ss Ind	ustry	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.	Completed	Elementary/Seconday		College (1-4	or 5+)	iife. D	ONOTusere Secret	tired)		3	Hea	ince Ge alth De	ce George's Count ch Department		inty
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Baltimore,	permit. Departr Importa any inju		21. Signature of Funeral S	ervice Licens				. Name and A				47	39 Bal	tim	ore Ave	nue
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Division	al or Attends safter death Director: /	Certificate:	4 Homicide	determined	28e. Place of	Injury - At ho etc. (Specify	ome, farm, stre	et, factory, of	fice		28f. Location (City or To		nd Number or i e)	Rural F	Route Number,	
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	To the within To the somple	Σ	only one) 3 ∐ Ce 29b. Signature ind title of		se Practioner: To	ine best of my	y knowledge, d		at the time, cense numb		e, and due to t		(s) and manner ate signed (Mo			
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State Registrar

Gerardo M. Gacad, 6510 Kenilworth Avenue, Suite #2700, Riverdale, MD 21035 31. Date filed (Month, Day, Year)

JUN 1 4 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month A^{M} Lennon Hazel Jr. 9 0.1111:44 June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Southern Maryland Hospital Prince George's Clinton 8. Date of Birth (Month, Day, Yea 5. Social Security Number Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Min. Months Days Hours **Director** 578-98-9998 45 Sept. Usual Residence of Decedent or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 🛚 Yes 2 🗌 No Temple Hills Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral Page 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a 3229 28th Parkway 20748 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: African If Yes, Give Year or Dates 3 Widowed 4 Divorced Ameri<u>can</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working United States life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Finance Secret Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic ew once. ည Lennon Hazel Sr. Patricia A. Olley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Hazel - Mother 3229 28th Parkway Temple Hills, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗔 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 22. Name and Address of Facility Stewart Funeral Home, Signatus of Funeral Service Licensee 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to s a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of performed?
Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 1 🗌 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Accident 1 Tes 2 🗌 No Investigation M Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3, Time o Time of Death Month -Physician/ ZolYear Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. Cit n, or Location of Death 4c. Cou MON 0 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** -874 Months Days Veranviana Yrs. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merital Hygiene. Important: If item 27 is marked other than "marked other th 10b. County 10c. City, Town or Location 10d. Inside City Limits Director INCOM 1 Kes 2 No 10e. Street and Number 10f, Zip Code Funeral 267 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b, Kind of Business Industry DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) GDOR WCK + Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည moved CRROLL Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tove Court Clintor MD tauking 2401 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Surial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) Burial 2 Cremation 3 Removal from State MOON ISEMEN Signatur 22. Name and Address of Facility HEXENDRIZE FERMINE CLINET LID COSSI 7527 old 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ser and Daily Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 26 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 certificate 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 \square No eral Director: A filled in by the fu Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ La Thi Hoang Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City. Town, or Location of Death Prince George's Doctors Community Hospital Lanham Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Country) Vietnam Months Days Hours Min. March Day 3 578-17-9115 78 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County death with the Maryland Director 10c. City Town or Location 10d. Inside City Limits 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1140 N. Capital Street, NW. 20002 Vietnam 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: "natural", 3 X Widowed 4 Divorced Specify Completed Asian Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumes? Elementary/Seconday (0-12) College (1-4 or 5+) Own. Home. Homemaker 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Hoang Van Chinh Dinh Thi Naot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Timberwood Avenue, Silver Spring, Maryland 20901 Andy Ngo - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 06/13/2011 Brentwood, Maryland 21. Sign 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 1800 New Hampshire Ave., Silver Spring, MD 20904 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if a y leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consecutions of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? signed by the atte I be detached for Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ THROMBOCYTOPENIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death? page 1 Yes 2 No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 🖳 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 ROAD. State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month P^{M} 2011 4:44 VERNA L. HALL June 8, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 26388 Clarence Christy Crisfield Somerset If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Months Hours Days 1 ☐ M 2X F 212-80-4480 96 Nov.17,1914 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 XNo Crisfield Maryland Somerset 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 26388 Clarence Christy Drive 21817 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify. Specify. White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Poultry Grower Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carnie H. Poole Flora Lena Cline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21817 26388 Clarence Christy Dr. Crisfield, MD Helen F. Campbell (Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/12/2011 Rehobeth, Maryland Rehobeth Baptist 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 21. Signature of Tenery Robert H. Bradshaw, 306 W. Main St. - Crisfield, MD 21817 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORONARY Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a ponsequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 → 10 2 NO 26. Place of Death (Check only one) Hospital:

Examine Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p for use as t cate has been signed by the page 2 should be detached ੬ Completed within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i Be Medical Certification: To

Physician

/Medical

Examiner

Director

Funeral

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Pages 1 and 2 should be filed within 72 hours after death with the Marylanment of Health and Martal Hyglene.

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permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tra once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARAD R SATYALIMD 1604 MARKET

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ST POWMOKE CITY MU

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State Registrar **JUN 14**

29b. Signature and title

32. Registrar's Signature

the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 10 James Edward Insley 20ÎÎ 5:16 р м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2638 Rebecca Lane Dorchester Cambridge Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug. 22, 1929 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) 1 🗹 M 2 🗆 F Hours Maryland 213-24-2405 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 2638 Rebecca Lane 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 X Married 2 🔲 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white rres, Give Year or Dates. 1951–53 3 🔲 Widowed 4 🗀 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) receiving supervisor wire cloth mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Goley Insley Irene Willey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris M. Insley wife 2638 Rebecca Lane, Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dorchester Mem. Park! 4 Donation 5 Other (Specify) 6/14/11 Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consuluence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the bunal-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Pregnant at time of death
Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: s after death.

I Director: After this c 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Sulcide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, within 24 hours aft To the Funeral Di completed filled in

State Registrar (Check

29b. Signature and title

31. Date filed (Month, Day,

B

MD

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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29d. Date signed (Month, Day, Year)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4 Day 201 Year JUNE ANNIE RUTH JAOUES 1:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death QUEEN ANNE'S COUNTY HOSPICE CENTER QUEEN ANNE'S CENTREVILLE Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Min. 1 M 2 T Hours (Month, Day, Year) 11/11/1915 Director 95 465-12-1194 Louisiana Usual Residence of Decedent or 28a-f show and 2 should be filed within 72 hours after death with the invaryiance [Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 🗆 Yes 2 🙀 No Maryland Oueen Anne's Stevensville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21666 121 Chesapeake Bay Drive U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced Caucasian Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page. Department of Heatu. Important: If item 27 is marn. Any injury or other traumatic ev ျ Mamie Alexander Quitman S. Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert P. Callens - Son 121 Chesapeake Bay Dr., Stevensville, Maryland 21666 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 06/17/2011 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ HEAT disease or condition MINTE Medical resulting in death) Due to (or as a consequence of) Examiner (orong Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last burial Physician/Medical that the death certificate be the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Dav Year Pregnant at time of death Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Yunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an The law page 2 s autopsy performed? Yes 2 10 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 XNO 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending

Box 68760 P.O. Records, or Attending Physician: Division of Vital funeral 24 hours after death Funeral Director: A completed filled in by Hospital

2 Acciden			М							
4 Homicio		28e. Place of Injury - At h building, etc. (Specif		ory, office		n (Street and Number or Rural Route Number, Town, State)				
29a. Certifier (Check only one)	2 Medical Examine	r: On the basis of examination	on and/or investigation,	in my opinion, death occurred a	at the time, date	cause(s) and manner as stated. e and place, and due to the cause(s) and manner stated. the cause(s) and manner as stated.				
29b. Signature a	nd title of certifier		2	9c. License number		29d. Date signed (Month, Day, Year)				
				167747		6/1/200				

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To the

State Registrar Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	_	Registrar			Cer	tificate of L	<i>Death</i>	_	leg. No.		2014
Physicia Medic		1. Decedent's Name (First, Middle, Elizabeth Ulri	ch King					2. Date of Dead June 13		Year	3. Time of Death 12:20 a M
Examin	er	4a. Facility Name (if not institution, g 3310 N. Leisure		, #127			Location of Death		4c. County Mon	of Death	
Funeral Director		5. Social Security Number 142–32–6329	5. Sex 1 ☐ M 2 🖾 F	(In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		9. Birth Cour	nplace (State or Foreign ntr Arizona
show at	or	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Lo	cation					10d. Inside City Limits
ne Maryla r 28a-f s notified	Funeral Director	MD Mont 10e. Street and Number	gomery	S:	ilve	r Spring					1 🗆 Yes 2 No
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ırs after deatl ural", or iten I Examiner n	by	11. Marital Status 1 ☐ Never Married 2 🙀 Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🛣 N If Yes, Give Year or Dates.		1	Vas Decedent of H f Yes, specify Cuba □ Yes 2 H No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Bla	ce - Americk, White,	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent (Specify only highest Elementary/Seconday (0-12)	s Education grade completed) College 11-4 or 5+		(Give I	dent's Usual Occup kind of work done o O NOT use retired) als Coord	luring most of worl		16b. Kind of B	of He	alth and
ld be filed Mental Hy, arked oth artic event	To Be	17. Father's Name (First, Middle, Las Robert G. Ulric	·				18. Mother's Nam Jean Eli	ne (First, Middle, N zabeth W		e)	
nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationship Eugene M. King/	1 21 /	19	9b. Mailin 3310	ng Address (Street a N. Leist	and Number or Rui ire World	al Route Number, Blvd.,	City or Town, S #127, S	State, Zip S ilve	Code) 2090 r Spring, MD
Page 1 ament of Harant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp		20b. Place cement Metrop	of Disponery, crem	sition (Name of natory or other place tan Crema	tory Ju	ne 13.	20c. Location Alexano	•	
permit Depart Import any inj		21. Signature of Funeral Service Lice	cerla		500	Name and Address rancis J. Univers	Collins	Funeral . W., Si	Home l	inc.	, MD 20901
Physician/		23a. Part 1. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final	omplications that caused by one cause on each line. Histiocyt		not ente						Approximate Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death)	Due to (or as a								
ed	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as a	consequence	e of):					\dashv	
be executed sician and burial-transit	cal Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence	e of):						
icate j phy: is the			- d						· · · · · ·		
To the Hospital or Attending Physician: The law requires that the death certificate E within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the terminate of the completed filled in by the funeral director, page 2 should be detached for use as the terminate of the completed filled in by the funeral director, page 2 should be detached for use as the terminate of the complete of the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal dea		Ectopic pregnance Other (specify)	у			ate of delive	very Day Year
hat the ed by detac	Ph	Part II. Other significant condition	s contributing to death bu	ıt not resulting	g in the u	nderlying cause giv	ren in Part I.	23e. Did tob	pacco use cont	ribute to t	the cause of death?
equires t	ted b	Sinoatrial Node	Syndrome Dy	ysfunct	tion	,	<u></u>	1 □ Ye	es 2 🖾 No	3 🗆 Pro	obably 4 🗆 Unknown
ding Physician: The law re h. After this certificate has be funeral director, page 2 sh	omple	Coronary Artery	Disease	-	-	-		24a. Was ar autops perforr 1 \(\sum \) Yes	SV	Were auto prior to co death? 1 \(Yes	opsy findings available ompletion of cause of
ian: 1	Bec	25. Was case referred to medical examiner?				26. Pl	ace of Death (Chec		Z LI NO	1 🗀 163	2 🗀 110
hysic li direc	2	1 Yes 2 X No	Hospital: 1 Inpatie	nt 2 = ER/0	Outpatien	ot 3 DOA	er: 4 D Nursing H	ome 5 Reside	ence 6 🗆 Oth	er (Specif	iy)
anding Plath.	Certificate:	27. Manner of Death 1X Natural 5 □ Pending 2 □ Accident □ Investiga			. Time of injury	work	∕at ? Yes 2 □ No	28d. Describe ho	w injury occurr	red	-
tal or Atterns at Directo		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin			farm, stre	eet, factory, office		28f. Location (St. City or Town		er or Rura	al Route Number,
the Hospi hin 24 hou the Funer npleted fill	Medical	only one) 3 Certifying N	Physician: To the best of maminer: On the basis of exalurse Practioner: To the b	amination and	or invest/	igation, in my opinio	n, death occurred a	at the time, date an	d place, and du	e to the ca	ause(s) and manner stated
T viti		29b. Signature and title of ertifier	Mark	•		29c. License	number 3874	2	9d. Date signe June		
10		30. Name and address of person vi Bradley Hunter,						Kensingt	on, MD	2089	95
Stat	е	31. Date filed (Month, Day, Year)	2011 32. Registrar	's Signature	Lo	arked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 10, 2011 Year Jacob Kanfee 10:00 am Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday) 8. Date of Birth 1 X M 2 🗆 F Days 217-72-1629 02712/1949 **Director** 62 Israel Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Maruland 1 Yes 2 X No Montgomery Olneu 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Bettswood Court 20832 U.S.A. E Israel 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian \$ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Contractor Landscaping Design th and Mental H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eliahu Kanfee Chaseeba Monsenegro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bettswood Court, Olney, Maryland 20832 Barbara Kanfee - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Judean Mem. Gardens 06/13/2011 Olney, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Tcell Lumphoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical attending p 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No 9 Unknown 4 Pregnant at time of death 9 Unknown Day Year ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24a. Was an Were autopsy findings available cate has prior to completion of cause of death? certificate Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide Medical 29a, Certifier

Box 68760 P.0. Records. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics of Vital Division hours after death.

uneral Director: A
ed filled in by the fu hin 24 hours a the Funeral C mpleted filled

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0060634

June 10, 2011

DHMH 17 Rev 7/2009

State Registrar didress of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Geoffrey Coleman, M.D.,

D37142

1355 Piccard Drive Suite #100, Rockville, Maryland 20850

June 08, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death .Day 2011 Physician/ Sue Loller June 19, Carol 9:15 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital Elkton Cecil Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Ye April 23 West Virginia Days 1 M 2 7 F 235-62-1958 **Director** 6.9 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Cecil Chesapeake City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3377 Augustine Herman Hwy. 21915 U.S.A. "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No White Specify: 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the Mental Health Counselor Mental Health Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gordon Moneypenny Bonnie Jean Burr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Loller (husband) P.O. Box 865 Elkton, MD. 21921 t If item 2 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Important; I any injury o 6/24/11 Forest Lawn Memorial Weston, West VA. 4 Donation 5 Other Specify, Sign of F ra Service 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech M00510 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, MD. 21635 Approximate ck, or heart failure. List only one cause on each line to Cause (Final or co dition Interval Between Onset and Death Immediate Cause (Final disease or co dition resulting in death) Physician/ Medical Examiner ALNU Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and the burial-tran that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending fter death. 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours

To the Funeral Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

RNE 31. Date filed (Month, Day, Year) 29d. Date signed (Month, Day, Year)

ELKTON, MD21921

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11^{Day} Physician/ June 201^{Year} Hazel Elizabeth McWilliams 6:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Chesapeake Woods Center Cambridge Dorchester Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🗆 M 2 🕱 March 19 214-10-0857 Maryland Director 90 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Dorchester Cambridge 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 525 Glenburn Avenue 21613 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other any injury or other trainer. 1 Never Married 2 Married þ ☐ Yes 2 🔀 No Yes, Give 1 Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) dietary aide hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter D. Jones Nettie Warfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8534 Briar Patch Drive, Denton, MD Jim Harmon p.r. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) East New Market Cem. 6/15/11 East New Market, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Advance Onset and Death Ph sician/ disease or condition Medical resulting in death) Examiner Cordio Vescal or Arterio se lenvic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 24 hours after death. autopsy performed? Yes 2 No 1 Yes 2 Ho 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 L No Other: 1 Tes ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 🗆 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 503 CAMBRIDGE BYRN NOMAN THANWY

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend 10e per FD, DOR, Registrar 6/23/11, LDR

1. Decedent's Name (First, Middle, Last) Certificate of Death Reg. No. 3. Time of Death 2. Date of Death MOANEY 1605 PM Physician/ DAPHNE JUNE 09 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE moun como OF MARY LAND UNIVER SLTY Birthplace (State or Foreign Country) if Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** (Month, Day, Year) Months Days Hours 1 M 2 F 4-80-696 1aryland Director Usual Residence of Decedent show 10d. Inside City Limits 10c. City. Town or Location 10b. County with the Maryland must be notified at **Funeral Director** 1 IV Yes 2 I No 23a or 28a-f urlock hester 10g. Citizen of What Country? 10e. Street and Number Venue permit, Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medic. I Examinar mu Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ity Detention Center Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) arles Marner 1403 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nysetta Warner Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/18/11 Cemetery Easton 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of acility
HENTY FUNEYAL
510 WAShingto 21. Signature of Funeral Service Licensee HOME, P. A Cambridge, MD, 21613 10 Naton St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFECTION E. COLI KLEBSIELLA Physician/ AND disease or condition resulting in death) Medical Due to (or as a consequence of) 4EARS **Examiner** DIJEASE RENAL END SM GE Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) 20 YEARS HYPER TEN SION attending physician and I for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last 20 YEARS DIABETES Physician/Medical TYPE b Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by MEUITS. CARAWEIC RENAL 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an OBESITY, NEPHRE CTOM IES BILARCAR autopsy performed? Yes 2 No page 2 s THROMBUSIS DEEP VE IN 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending work' 1 ☐ Yes 2 ☐ No Investigation completed filled in by the 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29c. License number 1197 99 1624 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2011 09 P25746 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

GREENE ST BATIMORE MD 5 -BILLICE 22 31. Date filed (Month, Day, Year)

JUN 1 4 2011

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SUSAN COLE MEREDITH APRIL 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MIMORIAL HOSPITAL EASTON TALBOT If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 8. Date of Birth 1 🗆 M 2 🖵 F Months Days Hours SEPT 23^{Yea} 220-66-4286 MARYLAND 56 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director MARYLAND QUEEN ANNE'S CRUMPTON 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 46 MATHEW DRIVE 21628 UNITED STATES 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give 2 X No altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: WHITE Completed COLL MIRIDITH Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Lepartment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event and once. Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY CHURCH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HOWARD M. COLE BETTY LOU BAYNE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, KRISTEN M. MEREDITH/DAUGHTER 2212 ROMANCOKE ROAD, STEVENSVILLE, MARYLAND 21666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State STEVENSVILLE, MARYLAND 1 Burial 2 Cremation 3 Removal from State CHESAPEAKE CREMATION 4 ☐ Donation 5 ☐ Other (Specify) APRIL 11,2011 Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN, & NEWNAM FUNERAL HOME P.A. 370 WEST CYPRESS STREET, MILLINGTON, MD 21651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician CENTRAL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner GUTONIOMIC** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to lor as a consequence of the burial-transit Cause (Disease or iinjury 1ND STAL-E that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be use as 1 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown detached for Month Pregnant at time of death 5 Other (specify) the g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 🕻 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Certificate: To 1 💢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 5 Pending 1 Tes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

0745

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ¥ Yes 2 □ No

28d. Describe how injury occurred 24 hours after deat Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, it may opinion, occar occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. the 29b. Signature and title of certifier Hul notus D0059487 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OF. TOTHN BOTS 1S 219 5. WASHINGTON 219 5. WASHINGTON ST. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#16a.b.PerFHPGC6-22-11 Gertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2011 Year June 5, 10:15A M Johnny Ε. McKenzie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Forestville Prince George's 1901 Altamont Ave Social Security Number 7. Age (In yrs. last birthday) 72 yrs. 8. Date of Birth (Month, Day, March 1 If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1x M 2 □ F Days 256-58-2580 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Forestville |Prince George's 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
United States 20747 1901 Altamont Ave 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 🙀 Married þ ☐ Yes 2 🔀 No Yes, Give 72 hours after Specify: Black 1 ☐ Yes 2xxNo Specify: "natural", 3 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Federal Government Elementary/Seconday (0-12) 12th College (1-4 or 5+) Packing/Satering Manager Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Emmett McKenzie Gastric Calloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Alice McKenzie/ Wife 1901 Altamont Ave, Forestville, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot Date cemetery, crematory or other place 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory 6/13/11 Riverdale, Maryland 21. Signature of Funeral Service Lig 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike, Forestville, MD 20747 MULUST Tura 23a. Part 1. Enter the diseas, or complicative that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Dementia, Lewy Body Type Physician/ disease or condition Years Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examir and -transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Carcinoma in situ prostate Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🙀 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending injury 2 Accident
3 Suicide М 1 Yes 2 No Investigation Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Funeral 1 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State
Registrar

Baltimore, Maryland 21215-0036

68760

Box

P.0.

Records,

Division of Vital

Cynthia M. Williams, M.D. 3720 Upton Street, Northwest, Washington, DC 20016
31. Date filed (Month, Day, Year)

JUN 1 4 2011

unthia m Milliams DO

and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29c. License number

H0058032

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #205 Per FH G917 7/15/2011 JH State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHARLES FRAZIER MCCOMBS, Sr. Month Day \mathbf{P}^{M} JUNE 8 2011 3:58 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10010 Cedar Hollow Lane Upper Marlboro Prince George's If Under 24 Hrs. **Funeral** . Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 577-40-5471 1 X M 2 🗆 F Hours Min. Florida 78 Director 0470371933 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If fenz 7s is marked other than "nature." or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d, Inside City Limits Md_{-} 1 X Yes 2 No P.G. Upper Marlboro 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10010 Cedar Hollow Lane 20774 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates. KOREAN 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ð 1 Yes 2 No Specify Black Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) 12th College (1-4 or 5+) Occupational Therapist Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph Lee McCombs Hazel F. Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah L. McCombs/Wife 10010 Cedar Hollow Ln., Upper Marlboro, Md. 20774 20a. Method of Disposition ☐ ROc. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 07/0P#2011 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Maryland Veterans Cem! 06/17/11 4 Donation 5 Other (Specify) Cheltenham, Maryland 21. Signature of Funeral Service Licenses Henry S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 "ach L de. rall Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner **EMPHYSEMA** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed TOBACCO SMOKE and I-tran Due to (or as a consequence of): resulting in death) Last attending physician of for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year signed by the a Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 XYes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 No 1 Yes 2 No 8 B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 \square Pending 2 Accident
3 Suicide
4 Homicide Accident Suicide Investigation 1 Yes 2 No

After this certificate illed in by the f

within 24 hours a

Medical

29a. Certifier

(Check

29b. Signature a

State Registrar

ss of person who completed cause of death (Item 23a) (Type, Print) M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 MONSERRATE, IVAN E.

32. Registra

6 Could not be

determined

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

ertifying wee Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

MD# 0101248519

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year) JUNE 9, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 1:45 A.M Robert Arnold Mosner June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Oakland Nursing&Rehabilitation Center Garrett <u>Oakland</u> 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) Funeral Nov. 13, 1931 Hours Min. Maryland Director 578-42-1621 Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County Director Garrett McHenry Md. 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A Funeral P.O Box 66 21541 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces?
1 X Yes 2 Black, White, etc. þ 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: White If Yes, Give 41 - 46Completed 3 Widowed 4 X Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Law Enforcement Government Be 17. Father's Name (First, Middle, Last)

John H. Mosner 18. Mother's Name (First, Middle, Maiden Surname)
Margurette 0'Conner 6 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 100 Salt Block Mt. Rd. Grantsville, Md. 21536 R. Jay Resh 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 16. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Md. Smithsburg Crematory 2011 22. Name and Address of Facility Signature of Funeral Service Lice 12525 Bradbury Ave. M01414 J.L. Davis Funeral Home Smithsbura.Md.21783 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or sequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the should be detached q Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 \square Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has ; page 2 s autopsy performe r this certificate heral director, page 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 🗖 No Hospital: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 Natural 5 Pending 2 🗌 No Investigation Accident within 24 hours after death

To the Funeral Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. Ligense number 29b. Signature ar 30. Name and address of person npleted cause of death (Item 23a) (Type, Print) Clard CUP 21990

State Registrar

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ PAULINE MARY MATTHEWS PM 2:24 Medical Tune 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Wicomico Nursing Home Salisbury 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min May Year 922 Country) 1 M 2 K 89 031-20-0372 Mass. Director Usual Residence of Decedent 10b. County 28a-f shov 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No Salisbury Md. Wicomico 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 900 Booth Street 21802 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Engineer Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Florence Sullivan Harold Conboy traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Unit 504 Crisfield, Md. Sandra Marshall----daughter Williams Street, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1. Burial 2 ☐ Cremation 3 ☐ Removal from State Princess Anne, Md. 4 ☐ Donation 5 ☐ Other (Specify) 06-09-201 Beechwood Cemetery 21. Sign of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 21853 Princess Anne. 1673 Somerset Ave. A. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dis se or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregp 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 4 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 TUNO 1 🗌 Yes ည ER/Outpatient 3 DOA 1 Inpatient 2 I Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 🗌 Yes injury atural 5 Pending 2 🗌 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 Easternshore Dr Salisbury MD 21804 Mahesha Thimmarayappa M.D. 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

A. parl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 12:27A M <u>Rilda McIntyre</u> Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Nicomico spice a Age (In yrs. last birthday)

87 Yrs. 8. Date of Birth (Month, Day, Year) **Funeral** If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 218-76-7042 1 □ M 2 🕶 F Countr Maryland **Director** 28 March 192/ Usual Residence of Decedent 28a-f show 10a. State filed within 72 hours after death with the Maryland at Hygiene. 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Wicomico 1 Yes 2 No Hebron 10e Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 26551 Meadowland Lane 21830 United States 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Completed 3 Widowed 4 Divorced Specify: White Year or Dates is marked other than "naturaumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. Paige ည Smith Jeanette Lewis Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Bragg 26551 Meadowland Lane, Hebron, Md. Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Grace Episcopal Ceme 06-11-201 Mt. Vernon, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave. Princess Anne, Md. 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between mediate Cause (Final Onset and Death ARDIOMYOPA TH Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) 23d. Date of delivery Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Pregnant at time of death Day been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Tunknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has ral director, page 2 autopsy performed death? 1 Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospita 1 ☐ Yes 2 PNo Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) HOSPI CR 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After 5 Pending Natural 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) DO053410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.D 1300 Huyam 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

₹ Z

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month SAMUEL DOUGLAS NAYLOR III 2011 0136 a June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Prince Georges Hospital Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yea
Sep 27, 1 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 🛛 M 2 🗆 F Yrs 579-96-6623 43 **Director** Sep 1967 Usual Residence of Decedent 28a-f show 10d. Inside City Limits it negatives are more to 18 section in the major it is not 28a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 K No MD Prince Georges Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20774 10069 Campus Way South Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 X Married ρ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced **Black** Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. METRO 12th Professional Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary A. Butler Samuel Douglas Naylor Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Washington, DC 20032 4339 4th St. SE Lenore Naylor - wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 5 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 6-16-2011 Suitland, MD 4 Donation 5 Other (Specify) Lincoln Memorial Cem 21. Signature of Funeral Service Licensee Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FATA CALDIAC Physician/ AKCHYTHMIA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) death certificate be executed the burial-transit Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 as the attending IF FEMALE nse s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Records, 1 Yes Completed peen 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of death? has certificate 1 Yes 2 No Division of Vital Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 000 1 Yes ပ 1 Inpatient 2 R/Outpatient 3 DOA Director: After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my known riedge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ation and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one the the 29b. Signature and title of certi 29c. License number မ ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DRIVE SATTALIAN

Registrar

State

32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 10:28 \mathbf{P}^{M} JUDITH ANN PHILLIPS JUNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S CENTREVILLE CORSICA HILLS NURSING HOME Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Days NOV. 21, Year 195<u>5</u> 1 🗆 M 2 🗶 I Months Hours MARYLAND Director 214-68-5691 55 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director QUEEN ANNE'S CENTREVILLE 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? items 23a Funeral 21617 USA 123 PRICE STREET death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black White, etc. ō ò 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after ☐ Yes 2 👿 No 1 ☐ Yes 2 X No Specify: WHITE "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "r. Elementary/Seconday (0-12) College (1-4 or 5+) HEALTH CARE **CNA** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ROSE MARIE QUILLEN PAUL EDWARD THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health an
Important: If item 27 is r
any injury or 1115 COURSEY LANE, DENTON, MD 21629 SEAN ROSEBROCK/ SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUNE 17, CHESTERFIELD CEMETERY 2011 CENTREVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each !! Interval Between Onset and Death Immediate Cause (Final Pnysician moma disease or condition resulting in death) Medical Examiner OUN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury signed by the attending physician and be detached for use as the burial-tranthat initiated events resulting in death) Last Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Other (specify) Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, 2 🗌 No 3 Probably 4 Unknown 1 Yes Completed plnous 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director; After this certificate has b page 2 s autopsy Division of Vital director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 No 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural iniury 5 \square Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who compi

31. Date filed (Month.

ex

JUN 1 4 20

(Item 23a) (Type, Print)

ause of death

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Mildred Horton Pulley 2011 3:05 P. 11 June Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Fox Run Drive Prince Georges 9317 Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Numbe 8. Date of Birth 1923 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min 416-46-5565 88 Alabama **Director** February 1 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland **Prince Georges** Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral with 23a 9317 Fox Run Drive 20735 United States items. 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. ō Yes 2 X No Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black "natural", 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Alabama Public Schools 6 years Elementary School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jackson Horton Evangeline Grisby 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a tant: If item 27 i 9317 Fox Run Drive; Clinton, Maryland 20735 Melba Pulley Broome (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State June 18,201|1 Donation 5 Other (Specify) Valhalla Memory Gardens Huntsville, Alabama 22. Name and Address of Facility R. N. Horton Company Morticians, Signatur Juneral Service Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Parkinson's Disease Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Dementia Sequentially list conditions, if any, leading to immediate Cause Electron assignment of Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Physician: The law requires 2 X No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. မ 1 Inpatient 2 ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined

State Registrar

31. Date filed (Month, Day, Year) JUN 1 4 2011

Stuart J. Goodman, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Medical

29a. Certifier

(Check

only one 29b. Signature and n

🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Clinton, Maryland

7501 Surrants Road; Suite 309

29d. Date signed (Month, Day, Year)

June

13, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Anthoney Michael 10:40A M 2011 June Medical ta. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel General Hospital Annapolis Date of Dill. (Month, Day, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1**X** M 2 □ F Hours 59 Yrs. **Director** 438-76-7323 1952 March Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director Md Prince George's Clinton 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 USA 7809 Royal Fern Ct. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 XMarried If Yes, Give Year or Dates. 1972-79 1 ☐ Yes 2 XNo Specify: Specify: Black Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Analyst permit, Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Sumame) ျ Catherine Lewis Hardy Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7809 Royal Fern Ct. Clinton, Md 20735 Sylvia Price / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🗆 Cremation 3 🔀 Removal from State Rest Haven Cemetery 6/21/2011 New Orleans, LA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 20722 3401 Bladensburg Rd Brentwood, Md 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) Approximate Interval Between Onset and Death Physician/ met astanc Squamus cavanouna nungs disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy 1 Yes 2 No 2 XN 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b, Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: injury 5 Pending 1 X Natural within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fun 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 3 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

STUAVT E.

31. Date filed (Month, Day, Year,

2003 medical Parkney #210

Annapolis, Md. 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

selouick, mo

32. Registra 's Signa

11-04351

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

llan Pasch Physician	/ R	For State of Maryland / Department of Health and Mental From State Certificate of Death Decedent's Name (First, Middle, Last)	Reg 2. Date of Death Month	. No.	3. Time of Death 1911 hrs			
Medical Examine		Alan Pasch a. Facility Name (if not institution, give street and number) 7300 Van Dusen Road 4b. City, Town, or Location of Death Laurel	June 9, 201	4c. County of Deat Prince Georg	h e's			
Funeral Director	2	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 297-14-7147 85 Yrs. 85 Yrs.	⊣	(MM/DD/YYYY) 9. Bi Forei 1925 C	gn puntry) Ohio			
Aaryland 28s-f show any Latonce.	1	State 10b. County 10c. City, Town or Location Silver Spring 10c. Street and Number 10f. Zip Code	100	g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 No untry?			
with the Maryland ns 23a or 28a-f sho be notified at once,		3152 Gracefield Road, MS223 20904	pecify Yes or No-	United S	tates rican Indian, Black,			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f she injury or other traumatic event, the Medical Examiner must be notified at once		1 Never Married 2 Married Armed Forces? 1 X Yes 2 No 3 X Widowed 4 Divorced If Yes, Specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc. Specify: White, etc.	ite			
5-0036 ed within 72 hours tygiene. other than "natu		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 pr 5+) Professor		Educati				
21215-0036 July be filed within 7 Menal Hygiene. marked other than ic event, the Medica	Q Q	17. Father's Name (First, Middle, Last) P. Jerome Pasch 18. Mother's Name Esther E	Brovermar	1				
MD 21 td 2 should lith and Mer m 27 is man aumatic ev	2	Paa. Informant's Name/Relationship (Type, Print) Rachel Grossman -daughter 19b. Mailing Address (Street and Number or F 1435 Jackson Avenue R 20b. Place of Disposition (Name of cemetery,	River For	cest, Illi 20c. Location - City o	nois 60305			
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	1	1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 6/12	/2011	Alexandria,	Virginia			
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/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Death			
d sit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): Due to (or as a consequence of):							
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Divisior Hospital or Attend 24 hours after death 28 Runeral Directorietely filled in by the	Medical Certification:	Suicide Could not be determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and	or Town, St	e(s) and manner as st	ated.			
To the within 2 To the complete	Medic	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Signature and title of certifier 29c. License number	at the time, date a	and place, and due to 29d. Date signed (M				
		O.C.M.E.		June 10, 2011				
R 40		 Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimo	more, MD 21	223				
Sta	te	31. Date filed (Month, Day, Year) 32. Registrate Signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Charles Beckwith Roberson June 201 Tear 6:00 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester Chesapeake Woods Center Cambridge 5 Social Security Number If Under 1 Year I If Under 24 Hrs . Age (In yrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 😾 M 2 🗆 F March Pay3 Year) 1914 Maryland 214-07-9932 97 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 817 Locust Street 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, þ 1 Never Married 2 X Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 white 1 Yes 2 X No Specify. Specify: WWTT 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) unknown College (1-4 or 5+) truck driver fuel oil company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Minnie E. Beckwith John F. Roberson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Stackhouse p.r. 13 Merryweather Drive, Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dorchester Mem. Park 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 6/14/11 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Sun ure of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on a h line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical ue to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1	State Registrar		Certificate of Death				Reg. No.				
Physicia	n	1. Decedent's Name (First, Middle, Last)		Ro	driquez		Date of Death Month	Day	Year	3. Time of Death		
/Medica	al .	Gabriel		110			June	_	2011	0630 M		
Examine	er	4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town, or Loca			4c. County	cil			
		11 Colonial Circle 5. Social Security Number 6. Sex	7 Age /ln v	rs. last birthday)	North Ea	Under 24 Hrs	8. Date of Birth		9. Birthp	place (State or Foreign	n	
Funeral Director		213-91-2274		Yrs.		ours Min.	Month, Day, April 21,	Year) 2011	Coun	7 Land		
	-	Usual Residence of Decedent			1 20		<u>r</u> ,				_	
yland how		10a. State 10b. County	10c.	City, Town or Lo	cation				1	0d. Inside City Limits		
Mar a-f sl	cto	Maryland Cecil		North Ea	ast					1 X Yes 2 □ No	,	
th the or 28	Director	10e. Street and Number								g. Citizen of What Country?		
23a ust b	ra La	11 Colonial Circle			21901				ed St			
er des tems	Funeral	11. Walla States	Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hispai f Yes, specify Cuban, M	nic Origin? (Spe lexican, Puerto F	cify Yes or No- Rican, etc.)		ce - Americ ick, White, (
BAITIMOFE, IMATYIANG Z.1.Z.13-UU.50 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, fire Madical Eximiner must be notified at once.	by F		l ∐Yes 2∭X No lfYes, Give Year or Dates:		1⊡Yes 2∭XNo <i>S</i> ∤	pecify:	Specia	^{fy:} Whi	ite			
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othe othe	Be C	17. Father's Name (First, Middle, Last)			18.	Mother's Name	(First, Middle, M	laiden Surna	ne)			
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Mary Id 2 shou Ith and It 27 is ma trauma		19a. Informant's Name/Relationship (Type.	Print)	19b. Mailir	ng Address (Street and	Number or Rura	l Route Number,	City or Towr	, State, Zip	Code)		
and 2 and 2 ealth n 27 i		Bailey R. Rodriguez			Colonial Cir			t, MD	2190	1		
altimore, rmit. Pages 1 au spartment of Hec portant: If item y injury or othe		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Rem	20i	 b. Place of Dispo cemetery, crer 	sition (Name of matory or other place)	June	^{ate} 20,	20c. Location				
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Fo the within Fo the comp	Me	29b. Signature and title of certifier	1		29c. License nu	umber	2	9d. Date sigr	ned (Month	, Day, Year)		
		1/1/19/11			D003	7130		June	18, 2	2011		
		30. Name and address of person who comp									_	
		THOMAS C	CRAWF	FORD		600 No	1th Walfe	e St, Bo	Strong	MD, 2128	7	
Sta		31. Date filed (Month, Day, Year)	C R AW S 32. Registrar's S	ignature				,				
Registr	ar	JUN 2 7 2011 Serve	4 10.19	W. Carrier								

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29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Monte)	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month	ı, Day, Year)
(and Hallac O.C.M.E. June 10, 2011	
30. Name and address of person who completed cause of death (Item 23a) Carol Allan MD Assistant Medical Evaminary 200 W Baltimore Street Baltimore MD 24233	
State Registrar Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registra's Signature Registrar	

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State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Mai	ryland / Depa <i>Cer</i>	artment of H <i>tificate of D</i>			iene eg. No.	20134					
	Physicia		Decedent's Name (First, Middle, George	Last)		Singer		2. Date of Death June 9	h	3. Time of Death 8:50P M					
-	Medic Examin		4a. Facility Name (if not institution, s				Location of Death		4c. County of Deat						
1	Funeral Director		5. Social Security Number 577–54–1273	5. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth J 4129 149	Year 1930 Huff 8	hplace (State or Foreign					
	iryland a-f show ied at	Director	Usual Residence of Decedent 10a. State 10b. County DC		10c. City, Town or Loc Washington					10d. Inside City Limits					
	vith the Ma 23a or 28a st be notif	eral Dire	10e. Street and Number 4201 Butterwort			10f. Zip Code 20016		1	0g. Citizen of What Co	ountry?					
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral	11. Marital Status 1 ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑	12. Was Decedent Eve Armed Forces?	er in U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba Yes 2 X No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:						
21215-0036	rithin 72 hou iene. r than "natu the Medical	Complet	15. Decedent (Specify only highes Elementary/Seconday (0-12) UNK)		(Give I	dent's Usual Occupa kind of work done d O NOT use retired) M Editor	ation luring most of work	ing	16b. Kind of Business EuroVisio						
Maryland 2	2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " traumatic event, the Mec	To Be	17. Father's Name (First, Middle, La Yosef Singer	st)			18. Mother's Nam	e (First, Middle, M (unk)	flaiden Surname)						
	d 2 should alth and M 1 27 is ma er traumai		19a. Informant's Name/Relationshi David Zahren -Pe		19b. Mailir 8 11 2	ng Address (Street a Mandan Te	and Number or Run errace Gr	al Route Number, eenbelt,	City or Town, State, Zip Maryland	20770					
Baltimore,	Page 1 and ment of Heal ant: If item 2 ury or other		20a. Method of Disposition 1 ⚠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		20b. Place of Dispo cemetery, cren Ohel Yako	sition (Name of natory or other plac V Cemeter	e) 6/14		20c. Location - City or Rosedale,						
Balt	permit. Page Department of Important: If any injury or once.	1)3		aquantes	4	<u>400 Powde</u>	<u>er Mill R</u>	<u>oad Belt</u>		ryland 20705					
	Physician/	S 03	shock, or heart failure. List or Immediate Cause (Final disease or condition												
	Medical Examiner	L	Sequentially list conditions	_{b.} Prostat	te Cancer					3 years					
	cuted nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	c	consequence of):										
09	cate be executed physician and s the burial-transit	edical E	resulting in death) Last	d.	consequence of):										
Box 687	ath certific attending for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	ey .		23d. Date of de Month	elivery Day Year					
ls, P.O.	requires that the de been signed by the should be detached	ed by Ph	Part II. Other significant condition Pneumonia	ns contributing to death but	t not resulting in the u	inderlying cause giv	ven in Part I.		bacco use contribute to	o the cause of death? Probably 4 💢 Unknown					
Division of Vital Records,	The law req ate has bee page 2 shoo	Somplet						24a. Was a autop perfor 1 Yes	sy prior to	utopsy findings available completion of cause of $2 \sum_{i=1}^{n} N_{i}$					
/ital	hysician: The law his certificate has b I director, page 2 s	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ※ No	Hospital:	nt 2 🗆 ER/Outpatie	Oth	er:		ence 6 Other (Spec	cify)					
on of	nding Physath. :: After this e funeral di		27. Manner of Death 1 X Natural 5 Pending 2 Accident Investig	28a. Date of injury (Month, Day,	28b. Time o	f 28c. Injur work	y at		ow injury occurred						
Divisio	al or Atte s after dea il Director	l Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi		y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Si City or Town	treet and Number or Ru n, State)	ural Route Number,					
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	(Check 2 Medical E	Physician: To the best of m caminer: On the basis of examiner: To the b	amination and/or inves	tigation, in my opinio	on, death occurred a	at the time, date ar	nd place, and due to the	cause(s) and manner stated.					
•	To t with Com		29b. Signature and title of certifier	mo	w		169951		June 10, 2						
R	-10		30. Name and address of person v John Hudson-Odo	i, CRNP 1524	ath (Ítem 23a) (Type, 5 Shady Gr	ove Road	,#130 Roc	kville,	Maryland 2	20850					
	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 4 2011	Server 6	s Signature										

DHMH 17 Rev 7/2009

			Please		ryland / Depa	artment of	Health and			•		
		_	Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of	Death	1001 10	Reg. No		(1 %)	
ياستور	Physicia Medic	al	Benjamin H. She	ellman				2. Date of De Month June	7 7			
	Examin	er	4a. Facility Name (if not institution, give st				or Location of Deat					
	Funeral		Prince George's 1 5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year			th	ince Ge	orge's	
	Director		577-24-8103 1 2 Usual Residence of Decedent	Y M 2 □ F	88 Yrs.	Months Days	Hours Min.	(Month, Da 9/23/	1922 1922	Co	hington, DC	
	and show	rol	10a. State 10b. County		10c. City, Town or Loc	eation					10d. Inside City Limits	
	Maryl 28a-f otifie	irec	Md Prince Ge	eorge's	Capital	Heights					1 X Yes 2 □ No	
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 6835 Jade Ct.			10f. Zip Code 2074	3		10g. Cit	izen of What C	ountry?	
	eath v	-une		2. Was Decedent Ev		Vas Decedent of H	Hispanic Origin? (S			14. Race - Am	erican Indian,	
36	after de al", or it xamine	Completed by I	1 【 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ N If Yes, Give Year or Dates. 19	0	Yes, specify Cub	an, Mexican, Puert Specify:	o Rican, etc.)		Black, Whi Specify: B1		
9	hours natura ical E	lete	15. Decedent's Edu	cation		ent's Usual Occu	pation		16b. K	ind of Business	a Industry	
215	in 72 e. nan "r	ᇤ	(Specify only highest grade Elementary/Seconday (0-12)	e completed) College (1-4 or 5+	life. Do	O NOT use retired	during most of wor)	rking				
2	I within ygiene.		12		Ma	achinist					- Fed Govt.	
and	e filed tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden .	Surname)		
ž	should be file and Mental F 7 is marked o raumatic eve		Grant W. Shellman 19a. Informant's Name/Relationship (Type)		1			Edwards				
Baltimore, Maryland 21215-0036	id 2 sho salth an n 27 is i		Michael W. Harris			g Address (Street Jade Ct	and Number or Ru • Capita	ral Route Numbe 11 Heigh				
ore			20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F	temoval from State		atory or other pla		Date	20c. Lo	ocation - City o	r Town, State	
Iţim	it. Pag rtmen rtant: njury		4 Donation 5 Other (Specify)		Ft. Linco			7/2011		ntwood,		
Bal	permit, Page Department of Important: If any injury or once.	1	21. Signature of Funeral Service Licenses	,			ess of Facility For ensburg F				Home 20722	
П			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one	cations that caused t	he death. Do not ente	r the mode of dyi	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between	
~	Physician/	1 1	Immediate Cause (Final disease or condition		ırdiac Arrl	nythmia					Onset and Death 1 day	
-	Medical Examiner		resulting in death)	· ·	consequence of):	01 4					1	
		iner	Sequentially list conditions, but any leading to the cause. Enter Underlying	. —	ntestinal l	этееа					1 week	
	be executed sician and burial-transit	Examiner	Cause (Disease or linjury that initiated events			***						
	oe executed ician and burial-transi	calE	resulting in death) Last	Due to (or as a	consequence of):							
260	physis	edic	d									
68	certifii nding use as	N/M	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of	pregnancy	1				23d. Date of de	elivery	
Box 6876(death he atte ed for	Physician/Medio	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 4 Pregnant at t	Fetal death 3 Lime of death 5 L	Other (specify)				Month	Day Year	
Ö.	nat the ed by ti detach		g ☐ Unknown Part II. Other significant conditions con	tributing to death but	t not resulting in the u	nderlying cause g	iven in Part I.	23e. Did t	obacco u	se contribute t	o the cause of death?	
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	ed by						1 🗆	Yes 2	□ No 3 □ F	Probably 4 Unknown	
cor	aw reg as bee 2 sho	Completed						24a. Was auto		24b. Were au	utopsy findings available completion of cause of	
Re	The Istanta	Con						perfo	ormed?	death?	s 2 2 No	
ta	ician: sertific ector,	Be	25. Was case referred to medical examiner?	ospital:		Tou	Place of Death (Che	ck only one)				
<u>_</u>	Physical direction	2	1 ☐ Yes 2 ☑ No Ho 27. Manner of Death	1 Inpatier 28a. Date of injury	nt 2 ER/Outpatien 28b. Time of	t 3 DOA 28c. Inju	The state of the s	lome 5 Resid			cify)	
o uc	nding ath. r: After e fune	icate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	Year) injury	wor	k? Yes 2 No	28d. Describe	now injury	occurred		
visio	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to completed filled in by the funeral director, page 2.	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/ - At home, farm, stre (Specify)	et, factory, office		28f. Location (S		Number or Ru	ural Route Number,	
Ö	spital on one a pours a peral D		29a. Certifier 1 Certifying Physic	ian: To the best of m	v knowledge, death o	ccured at the time	e, date and place, a	and due to the ca	iuse(s) an	d manner as st	ated	
	ne Hoo	Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse	er: On the basis of exa	imination and/or invest	gation, in my opin	ion, death occurred	at the time, date a	and place,	and due to the	cause(s) and manner stated.	
	To the To the Control	_ 1	29b. Signature and title of certifier	Funalen	an)	29c. Licens	e number	12	29d. Dat	e signed (Mont	th, Day, Year)	
	2+1		- Jarhad f	unacu		100	7286	/ 5	6	18111		
R	3+1		30. Name and address of person who cor	mpleted cause of dea	ath (Item 23a) (Type, P	olis Rd	Cleun Da	ile MD	2	0769		
	Stat Registra	e	31. Date filed (Month, Day, Year) JUN 1 4 2011	32. Registrar	s Signature						-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar		tificate of D		,	Reg. No.	F	2013	5	
Physic	ian/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea		1 Year	3. Time of Deat		
	dical	Aubrey knodes Spruili		4h City Town or	Location of Death	June 1.		ty of Death		₽M	
Exam	illier	11907 Coronada Place		Kensing				Montgomery			
Funera Directo	_	5. Social Security Number 238-40-8067 6. Sex 1X M 2 F 86	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt June 20	, Year) 924	9. Birti Cou	hplace (State or For untry) NC	reign	
and show	į	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Loc	cation					10d. Inside City Lin	mits	
Maryii 28a-f otifiec	irect	MD Montgomery	Kens	ington					1 ☐ Yes 2 🛭	No	
s 23a or	Funeral Director	10e. Street and Number 11907 Coronada Place	· · · · · · · · · · · · · · · · · · ·								
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ed by Fur	1 Never Married 2 Married 1 Year Size 10//		Vas Decedent of Hir FYes, specify Cubar ☐ Yes 2 1 No		ecify Yes or No- Rican, etc.)	Bi	ace - Amer lack, White ify.Whit			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours affer Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", only injury or other traumatic event, the Medical Exam	Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give k	lent's Usual Occupa kind of work done d D NOT use retired) Chanic	ation uring most of work	ing	16b. Kind of		Industry		
/land // d be filed w Mental Hyg arked othe	To Be				18. Mother's Nam	e (First, Middle, e Tarki	Maiden Surnar ngton	me)			
t, Mary nd 2 should ealth and N m 27 is ma ier trauma		19a. Informant's Name/Relationship (Type, Print) Rose Lorraine Spruill/Wife	1190	g Address (Street a			-				
Limore . Page 1 at timent of H. tant: If iten jury or oth		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	te of H	natory or other place leaven Cer	metery J	une 16, 2011		_Spr:	ing, MD		
Ball permit Depart Impor	ouce	21. Signature of Funeral Service Licensee	50 50	Name and Addres rancis J. Univers	s of Facility Collins ity Blvd	Funera W, S	l Home ilver S	Inc. Sprin	g, MD 209	01	
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cords, P.O. I law requires that the nas been signed by the	2	Part II. Other significant conditions contributing to death but not les	sulting in the ur	nderlying cause giv	en in Part I.				the cause of death?		
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Vital F ysician: T is certifical director, p	BeC	25. Was case referred to medical			ace of Death (Checi		2 [] [NO]	T L Tes	; 2 ∐ No		
ISION Of VITAI Attending Physician: A death. ector: After this certific by the funeral director,	ار ا	1 Yes 2 No 1 Inpatient 2	ER/Outpatien	t 3 DOA Othe	4 ☐ Nursing Ho				ify)		
on on on on on on on on on on on on on o	icate	1 Natural 5 □ Pending (Month, Day, Year) 2 □ Accident Investigation	injury	work'		28d. Describe h	ow injury occu	rrea			
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Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	Medical		on and/or investi	igation, in my opinio	n, death occurred a	the time, date a	nd place, and d	due to the c	cause(s) and manner	stated.	
Nith To t		29b. Signature and title of certifier 405eph m. Haggerty my	D.	29c. License			29d. Date sign				
vot		30. Name and address of person who completed cause of death (item			32407		June	13,	2011		
w.		Joseph M. Haggerty. MD 9707	7 Medic	al Center	Drive,	#300, R	ockv i 11	Le, M	D 20850		
S ⁱ Regis	tate trar	31. Date filed (Month Cay Yar) 4 2011 32 fegistrar's Signa	B. As	ented							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 55 A.M Medical Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c County of Death last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country 1 XM 2 1 Month Day, Y **Director** Usual Residence of Decedent items 23a or 28a-f shov 10a. State 10b. County injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Black, White, etc. ò ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify "natural". Completed 3 Widowed 4 Divorced 5 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ပ 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rull State, Zip Code) Route Number permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 20a. Method of Disposition 20b. Place of Disposition (Name of 1/ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility an Part 4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Alzhermers Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death detached Unknown Division of Vital Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an completed filled in by the funeral director, page 2 autopsy perform 1 Yes 2 No 20 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Dother (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Suicide Investigation 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License numbe

State Registrar 10000063

4/05

M

Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8 Day Physician/ LUCY IMOGENE THURSBY JUNE 2011 \mathbf{A}_{M} 7:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CORSICA HILLS NURSING HOME CENTREVILLE QUEEN ANNE'S Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Days Hours Director 090-20-6418 84 06/26/1926 NEW YORK Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No MARYLAND | QUEEN ANNE'S **STEVENSVILLE** 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 617 LOVE POINT ROAD 21666 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces ρ Black, White, etc. "natural", or 1 Never Married 2 Married after Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 XWidowed 4 ☐ Divorced Completed and 2 should be filed within 72 hours and Health and Mental Hygiene. Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ FRANK EARL PECK LAURA MAY YEARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BONNIE L. COLEMAN / DAUGHTER 617 LOVE POINT ROAD, STEVENSVILLE, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 s
Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State CHESAPEAKE CREMATION 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 06/09/2011 CENTER 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events sician and burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month for Pregnant at time of death 5 Other (specify) Month Day Year ed by the a g 🗍 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform 2 🗌 No 1 Yes Hospital or Attending Physician; 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Natural 5 Pending work? Accident Investigation 2 🗌 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined thin 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

JUN 1 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June Mariann Jean Tolliver 10:00 Ам 11 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2308 Coleridge Drive Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Ye April 23, **Funeral** 9. Birthplace (State or Foreign 1 M 2 X 010-44-5026 Hours 59 Director 1952 Waltham, MA Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2308 Coleridge Drive 20910 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 🛛 No Maryland 21215-0036 1 Yes 2 No Specify. Yes, Specify: White 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Cashier should be filed with nand Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tivis Martin Tolliver Patricia Mary Madruga permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael B. Tolliver / Brother 3280 Karen Drive, Chesapeake Beach, MD 20732 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 6/13/2011 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, Virginia Signature of Juneral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. on 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequenc Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause, Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and-trar Due to (or as a consequence of): resulting in death) Last as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 호 Month Day 5 Other (specify) Year Pregnant at time of death detached the þ eath but not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing 23e. Did tobacco use contribute to the cause of death? signed þ be 1 🗌 Yes 2 ☐ No 3 Probably 4 ☐ Unknown should Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 **Z**No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4
Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending work? 1 🔲 Yes 2 🗌 No 24 hours after death Funeral Director: ₽ Investigation 6 Could not be completed filled in by the 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. al Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only one) ng Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and t 29d. Date signed (Month, Day, Year) 00212 person who completed cause of death (Item 23a) (Type, Print) AAhmed Heshmat, 10301 Georgia Avenue, Suite #203, Silver Spring, MD 2090231. Date filed (Month, Day, 32. Registr State JUN 1 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manth 19 2011 Year 7:00a M Grace Jackson Trout Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Renaissance Gardens - Riderwood Silver Spring 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. **Funeral** Days July 21 578-44-1623 92 **Director** Usual Residence of Decedent 28a-f show ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maruland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3116 Gracefield Road - Victoria Place 20904 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give \$ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Supreme Court Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Jackson Emma Thompson Just 1 and 2 sh. Just 1 and 2 sh. Just 2 sh. Important; If item 27 is many injury or other 2 sh. Just 2 sh. Ju 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Curtis - Daughter 240 Mowbray Road, Colesville, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery [06/14/2011 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Huguson |11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Facial Basal Cell Carcinoma with Metastases disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of, the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗓 No Month Day ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Adrenal Insufficiency 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Sjogren's Syndrome has autopsy Chronic Obstructive Pulmonary Disease this certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA nin 24 hours after death.

The Funeral Director: After this repleted filled in by the funeral standard. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 Accident
3 Suicide 2 | No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D44156 llegrow no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Registrar

3110

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Othi, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2011 ROGER LEROY THOMPSON JUNE :05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chester River Hospital Kent Chestertown If Under 1 Year | If Under 24 Hrs 8. Date of Birth
(Month, Day, Year)
April 12 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 🔀 M 2 🗆 F Maryland Director 1929 212-28-2425 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 412 Everett Rd. 21111 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. th and Mental Hygiene. 27 is marked other than "natural", or i traumatic event, the Medical Examin þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 <u>Truck Driver</u> Motor Freight Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Leroy Thompson Irene Lugenbeil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Beatrice Thompson (wife) 412 Everett Rd. Monkton, MD. 21111 item 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State cemetery, crematory or other place, 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) Kent Cremation Service 6/21/11 Smyrna, DE. 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech 21. Signature of Funeral Service Liech M00510 118 West Cross St. Galena, MD. 23a. Poil 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hand failure. List only one cause on each line. Approximate Interval Between Immediate C se (Final diseas ondition resulting in death) nset and Death Physician/ rectange A roumon カイン Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner that the death certificate be executed Cause (Disease or iinjury that initiated events 51212 Alzheimers burial-tran Due to (or as a consequence of) resulting in death) Last attending physiciar IE FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery for in the past 12 months? Month Pregnant at time of death 1 Yes 2 No 9 Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe The 1 🗌 Yes Yes Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certific completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 00 1 Yes 1 Inpatient 2 မှ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the l within 2 To the F only one 29b. Signature and titl of certifier 29d. Date signed (Month, Day, Year) D0051735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

Frederick Delboy,

31. Date filed (Month, Day, Year)

M.D.

32. Registrar's Signature

21215-0036

Baltimore, Maryland

68760

Box (

Records.

Division of Vital

arked

6602 Church Hill Rd. Chestertown MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend#7. PerFHPOO6-14-11cm Certificate of Death 1. Decedent's Name (First, Middle, Laşt) 2. Date of Death Month 6 Physician/ Year 201 WILCOX Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death mestalle meilville Ninsin nn If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth (Month, 18-44-1 🗆 M 2 Months Days Hours **Director** Usual Residence of Decedent or 28a-f shov 10a. State 10c. City, Town or Locațion 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland any injury or other traumatic event, the Medical Examiner must be notified at Director Yes 2 No 10f. Zip Code Street and Number 10g. Citizen of What Country? Funeral "natural", or items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 21 No Specify: 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) omesti omemak Be ber's Name (First, Middle, Maiden Surname) Father's Name (First, Middle 18. M မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2001 & nand Joveta SE. Washington DC 1746 Benning aughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 15-2011 Landover, MD tarmoni 22. Name and Address of Facility Wisemon Funeral Home 2073 1527 Old Heronaura Ferry Rel Clinton MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death publicaroiz Cardiovasculor Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if at y, reading to immediate cause. Enter Underlying Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the invertal director, page 2 should be detached for use as the burnal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death g Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 M Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 V Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a d title of certifier 29d. Date signed (Month, Day, Year) 6/10/2011 10431

State Registrar 31. Date filed (Month, Day,

Colon 1

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06 7:54 A Willie Henry Wade 2011 Medical 4a. Facility Name if not institution, give street and number) Bowie Health Center 15001 Health Center Drive Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Bowie Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs, last birthday) 73 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 XM 2 F Months 04/16/1938 North Carolina **Director** Yrs 238-60-3009 Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Bowie 1 🖾 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15716 Piller Lane 20716 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married 1 Yes 2 XNo
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) . Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than ' jury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 8th Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unknown Alice Wade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carla Wade/Daughter 15716 Piller Lane Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. aGrange Cemetery 06/18/2011 4 ☐ Donation 5 ☐ Other (Specify) LaGrange, NC 22. Name and Address of Facility Marshall-March Funeral Home Signature of Funeral Service Licensee nach 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition respiratory or condition respiratory or cause on each line.

Complication from exploration laparotomy and respiratory or sigmoid colon Approximate Interval Between Onset and Death Physician Medical resulting in death) Due to (or as a consequence of) Examiner Metastatic Colon Cancer Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examir attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? by Cardiomyopathy Completed 1 Yes 2 No 3 Probably 4 Tunknown Diabetes Mellitus Type 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy after death.

Director: After this certificate 1 ☐ Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 6 1 Tyes Other: 2 (No 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of Lentier 29d. Date signed (Month, Day, Year) 06/14/2011 D43351 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ikechi Okwara 12200 Annapolis Road #316 Glenn Dale, MD 20769 31. Date filed (Month)

State

Registrar

JUN 1 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Susan Anne Walsh-Day June 9, 2011 ar 7:34pm M Medical 4a. Facility Name (if not institution, give street and number)
7007 Maryknoll Avenue 4c. County of Death **Examiner** 4b. City Town, or Location of Death Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 6. Sex **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 1 🗆 M 2 😾 F Months Days Year 944 March Day, 67 579-90-2841 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location Bethesda 10d. Inside City Limits Director MD Montgomery 1 Yes 2 🙀 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20817 7707 Maryknoll Ave. 12. Was Decedent Ever in U.S. Armed Forces

1 ☐ Yes 2 ☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian White White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🏲 No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2^{College (1-4 or 5+)} Elementary/Seconday (0-12) Montgomery County Government Property Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Rosalie Camalier Raymond A. Walsh Jr. 19a. Informant's Name/Relationship (Type, Print) Paul Leslie Day/ Husband 19b7 Meiling Address (Street and Number of Rund Borna Number City MDown Olde Jip Code) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Metropolitan Crematory 06/ 10/11 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Francis J. 500 University Blyd. West Silver Spring, MD 20901 Collins Funeral Home 21. Signature of Funeral Service Licenses 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Breast Cancer Physician/ years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Causo (Disease or i that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No 1 ☐ Yes 2012 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably Y Unknown 24b. Were autopsy findings available 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 s autopsy
performed?

Yes 2 No prior to completion of cause of death? 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 🐴 No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Natural
Accident injury 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

10

DHMH 17 Rev 7/2009

State Registrar 5530 Wisconsin Avenue, #1125,

egistrar's Signature

Chevy Chase, MD 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bruce Kressel, MD

31. Date filed (Month JDN 17) 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

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Bruce Orlando Yansen

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23	30. Name and address of person Patricia Aronica-Pollal	k MD. Assistant M	ledical Exar	miner 9	000 W. Baltin	nore Str	eet, Balt	imore, MD	21223		
State Registrar	31. Date filed (Month, Day, Year)	32. Registra	's Signature	es.							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Evelyn Zucker 2011 10:25 9, June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Aspenwood Senior Living Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) MD 578-24-2059 1 M 2 X Hours Min Feb. 24, 86 Months **Director** Usual Residence of Decedent ural", or items 23a or 28a-f show Examiner must be notified at . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. It ant: If I flew 27 S marked other than "natural", or items 23a or 28a-f sho land; I flew 27 S marked other than "natural", or items 23a or 28a-f sho lury or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d, Inside City Limits Director MDMontgomery Silver Spring 1 🗌 Yes 2 🏝 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14400 Homecrest Road 20906 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Deceden... Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ⅔ Widowed 4 ☐ Divorced If Yes, Give Year or Dates SpecifiWhite 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Harry Lawrence Cohn Sophia Bessie Goldman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. McCarthy/Guardian permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to 4405 East-West Highway, #201, Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State June 15, 2011 Mt. Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Frederick, MD 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring,MD 20901 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Neoplasm of Unknown Primary Site Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner S crentially list contains if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and debts be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 Yes 2 X 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 Yes 2 No 3 Probably 4 Unknown plnods Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy death? After this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ASSISTED LIVING 2XXNo 1 🗌 Yes မ Other: 6 Other (Spec 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Accident 24 hours after deat Funeral Director: Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F 3 Certifying Nurse Pyactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of_certifie 29c. License numbe 29d. Date signed (Month. Dav. Year) D34032 June 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeanne Asher, MD 3720 Farragut Avenue, Kensington, MD 20895 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month **Physician** Rebecca Joan Abbott /Medical 2011 15. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore <u>Greater Baltimore MED</u> Towson 8. Date of Birth (Month, Day, Year) 9.

June 26,1987 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 212-19-9645 1 □ M 2 XF Maryland Director Usual Residence of Decedent per it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland De artment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show am injury or other traumatic event; the Medical Examiner must be notifiled at announce. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Directo Baltimore MD Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 4252 Mt.Carmel Road 21155 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married 21215-0036 White 1 ☐ Yes 2 No Specify. Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Eiementary/Secondary (0-12) Healthcare Phlebotomist laryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joan Rohe Mark William Kahl ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4252 Mt.Carmel Road, Upperco, MD. 21155 Daniel Abbott - Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donardy 5 ☐ Other (Specify) Baltimore, Maryland Holly Hill Cemetery 6/27/11 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityConnelly Funeral Home of Essex 300 Mace ave.Essex, Maryland 21221 Pail 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardi quilmonary arrest
Due to (or as a consequence of): disease or condition resulting in death) 30 min /Medical Examiner Multiorgan failure 12 hours Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner spital or Attending Physician: The law requires that the death certificate be executed ours after death.

Beral Director: After this certificate has been signed by the attending physician and filled in by the functed director, page 2 should be detached for use as the burnal-transit Possible postpartum sepsis
Due to (or as a consequence of): 16 hours by Physician/Medical IF FEMALE: 23c. If yes outcome pf pregnancy
1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☑ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 06 14 2011 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death.

1 □ Yes 2 □ No 24a. Was an autopsy perform 12 Yes 2 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

To the Hospital of within 24 hours af To the Funeral D Medical SW

State

29a. Certifier

29c. License number

D0038352

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

06, 23, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Schwartz MD 6701 N. Jay, Year) 32. Registrar's Signature

and manner stated.

Charles St.; Towson, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland		irtmen tificate			and M		2.0		201.1.9
			Registrar 1. Decedent's Name (First, Middle, Last)	Ceri	uncate	OID	eaui	Т	2. Date of De	Reg. No U		3. Time of Death
40	Physicia Medic		Lillie M. Allen						Month L	Day 26	Year	12:30 AM
	Examin		4a. Facility Name (if not institution, give street and number) Franklin Square Hospital		BA	Him				BA	ty of Death	eren
	Funeral Director		5. Social Security Number 6. Sex 1 M 2X F 7. Age (In yrs. lact 1 M 2X F 86	st birthday) Yrs.	If Under Months	1 Year_ Days	If Under Hours		8. Date of Bir (Month, Da	th y, Year) 1925	Cour	place (State or Foreign htry) Cy IAND
	land show d at	tor		Town or Loc			-					10d. Inside City Limits
	rs after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at	Director	MD BALTIMORE 1 10e. Street and Number	ROSE					Т	10 000		1 Yes 2 No
- D	with th	Funeral I	7925 BRIDGE AUENUE		10f. Zip		123	7		10g. Citizen of	S, S,	
	death r items ner m		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	/as Decede Yes, speci	ent of His fy Cubar	spanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)		ce - Americ	
790	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates.	1	☐ Yes 2	No	Specify:					ACK
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Marylan	should be fil and Mental is marked aumatic ev	1	19a. Informant's Name/Relationship (Type, Print)				nd Numbe	er or Rural	Route Numbe	er, City or Town,		Code) 21237
	and 2 s Health tem 27		Stepitanie CANTY/NIECE 20a. Method of Disposition	7925 ace of Dispos			AVE	/	05 <i>E I)A</i> ate	LE, M	ARY I	AND State
altimore,	~ 0 4- 1-		1 Burial 2 Cremation 3 Removal from State	metery, crem	atory or of	her place	e RV	7/01	2011	LANSO	ואו נעוס או	E. MARULANA
Balti	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee	22.	Name and	Address	s of Page	ED	ERRIC	KCJ	ONES	E, MARY AND FIH, E.A.
			23a. Part 1. Enter the disease, or complications that caused the death.	76	II PA	RKI	14715	· 4 U	12. BA	C/junok	E, M.	Approximate
	Pnysician/	0.3	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ry A	ailur	સ						Interval Between Onset and Death
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687	certifica nding p use as	ın/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnan							23d. D	ate of deliv	/ery
. Box	ne death the atte	ysicia	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Other (sp	regnancy ecify)	/			M	lonth	Day Year
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resu	lting in the ur	nderlying c	ause give	en in Part I	l.				he cause of death?
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	he Hosi in 24 ho ne Fune pleted f	Medical	29a. Certifier (Check Check only one) 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practioner: To the depending Nurse Practioner:	and/or investi	gation, in n	ny opinior	n, death oc	curred at	the time, date a	and place, and d	ue to the ca	ause(s) and manner stated.
	To the voice of the company of the c	_	20h Signature and title of certifier		200	Liconco	number	70 1	11057	20d Data sign	ed (Month,	
			30. Name and address of person who completed cause of death (Item: 1 temphen X, Smith, Mb 2 \$70 fi	23a) (Type, Pr	rint) Ri.	7 \$	Raito	mere	, md.	21234		
3	Stat Registra	е	31. Date filed (Month, Day, Year) 32. Recentrar's Street	Kel		•						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Paola Antonelli Abbott 2011 11:15A Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3217 Birchmede Drive Ellicott City Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Country)
Italy (Month, Day, 218-72-5929 Director 17 Tune. 1937 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County Director 10d. Inside City Limits 1 Yes 2 No Maryland Howard Ellicott City 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3217 Birchmede Drive 21042 USA/Italy Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 Yes, Give 1 Yes 2X No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher/Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gino Antonelli Armida Vianelli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Kathleen Abbott/daughter 4101 Greenway Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🄀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Final Journey Crematory 06/28/11 Woodbine, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Going Home Cremation Service P.O. BOx 784 MO1251 Beverly L. Heckrotte, P.A Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ nopr ON pronth Medical Due to (or as a c Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Dire to (presidents) of physician and s the burial-trans Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 275 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy or Attending Physician: of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending injury Division To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aft completed filled in by the fur 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) eland 0 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20451 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ [□]2011 1200 PM <u>Choo Ja Ann</u> June 24, Medical 4a. Facility Name (if not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 1200 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec 28, 1921 **Funeral** Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Months Days Hours Director Yrs. 216-11-8930 Korea Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland at 10c. City, Town or Location Director 10d. Inside City Limits traumatic event, the Medical Examiner must be notified 11/20/1 1 Yes 2 No Maryland Montgomery Potomac ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 11124 Captains Walk Court 20878 Korea hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. ρ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", 3 X Widowed 4 Divorced Completed Specify: Asian Ann 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Heath and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event; the ones. Homemaker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) Chooja, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jae-Soon Ann Ssi Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Amy Cha/daughter 11124 Captains Walk Court N. Potomac, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematdry 06/29/11 Woodbine, MD Signature of Funeral Service Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardiac Onset and Death Physician/ 30 minutes disease or condition Medical resulting in death) Examiner Spirator weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events resulting in death) Last ongestiv months attending physician and for use as the burial-tran Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death
Unknown Day Year ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D70144 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rocks, lle Michael Murra 9901 Medical Otr Dr MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State

Registrar

JUN 28 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Items# 11,18,19a,per fh,g91/ —12-11 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:00 A M Physician/ Month ALSTON USIE 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death NURSING HOME BALTIMORE 9. Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral Month, Day, Year) 09-09-192 212-30-8056 Months Hours Min Director Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location with the Maryland notified at 10d. Inside City Limits Funeral Director BALTIMORE MD 28a-f 1 ¥ Yes 2 □ No 10e, Street and Number 10g. Citizen of What Country? ms 23a or must be n ROLAND VIEW USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 M 1 Yes 2 No If Yes, Give Year or Dates. ò filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: BLACK "natural" Completed 3 X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC HOUSEKEEPER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ PATTIE KNIGHT Williams Page 1 and 2 should be FLOYD KNIGHT 19a. Informant's Name/Relationship (Type, Print) (DAVGHTER)
GENEVA ATKINS - GRANT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 938 WINdbrooke Dr. GAITHERSburg, MD. 20879 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Cther (Specify) ь BALTIMORE, MD Department of Important: If any injury or once. RIOGE CEMETERY DRUID 22. Name and Address of Facility VAUSHN GREENE FUNELAUSUKS Signature of Eyne al Service Licensee MO ROAD. BALTIMORE, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) DEMENTIA JA KAON-Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) rsician and burial-transit requires that the death certificate be executed Cause (Disease or import that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day Month Year ate has been signed by the a page 2 should be detached g Unknown P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Hospital or Attending Physician: To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending hours after death Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6/24/11 D0059056 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 WEST 400 St 21211 Belt MD State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Dav Ruth Kathleen Allen 7 - 15 24 2011 Medical Tune 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Center Towson Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min OCL. 27 Year 918 216-05-0096 92 Mary land Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City, Town or Location Director 1 ☐ Yes 2 🛣 No Baltimore Timonium Maryland 10e. Street and Number 10f. Zip Code r items 23a or ner must be n ō 10g. Citizen of What Country? Funeral Plumbridge Court #304 405 21093 U.S.A. Je filed wittin...
ental Hygiene.
arked other than "natural", or items
"> ovent, the Medical Examiner m 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married δ AIUN KW+M altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐xNo Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Court Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ Department of Health and Ment.
Important: If item 27 is marken any injury or and injur John Peter Roeseke Augusta Bangert injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405 Plumbridge Court #304 Timonium, Maryland 21093 Joanne A. Wolf / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cardens of Faith Cemetery 6/29/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Scrube Littinses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death neumone Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** VOK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death
Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Dulmanan 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should FIBULATO 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? 2: No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Z No 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Mannef of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Cynflug Smaw Mo DU057347

Registrar

DHMH 17 Rev 7/2009

State

670, N. Chaires St Bultimore MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUI. aNO MIN

2. Registrar's Signature

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	Dhusisi		Decedent's Name (First, Middle, I	Last)		_			2. Date of D	Death Da	y Year	3. Time of I	Death
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	r 28a	Director	10e. Street and Number				10f. Zip Code	Lington		10g. Cit	izen of What Cou	ntry?	
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	er de sitams	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		S. 13.	Was Decedent of his Yes, specify Cub	Hispanic Origin? (an, Mexican, Pue	Specify Yes or it rto Rican, etc.)	10-	 Race - Ameri Black, White, 		
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Maryland 21215-0036	S S S S S S S S S S S S S S S S S S S	-	19a. Informant's Name/Relationship	(Type, Print)			ng Address (Street	and Number or F	Rural Route Num	ber, City			
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Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3		20b. Pl	ace of Dispo emetery, crer	sition (Name of natory or other pla	ce) June	e 24,	20c. L	ocation - City or T	own, State	
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Box 6	death certificate I e attending physi d for use as the b	Physician/Medi	JF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of deliv	ery	
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ita		Be C	25. Was case referred to medical examiner?					26. Place of De	eath (Check only		1 10 165	2L NO	
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on C		ion	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	Wo	ryat rk? ∣Yes 2 □ No	28d. Describ	e how inju	ry occurred		
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	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner sta	ated.		29c. Licens				te signed (Month,		
	with cor) (Flatis	il (M			56345			22, 201		
•	U		30. Name and address of person wh	o completed cause of c	eath (Item	23a) (Type,					,		
			Piush Patel, M.D					e, Germa	ntown, l	Mary1	and 2087	4	
	Sta Registr		31. Data UNINA 218 2011	32. Registr	s Signa	alle							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20% tor ROWA Medical Eacility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death '05 TIMOR OWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Security Number 7. Age (In last birthday) 9. Birthplace (State or Foreign 1 □ M 2 KF Days Hours Min **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTI MORE 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral 211 01 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: item 27 is marked other than "natural", other traumatic event, the Medical Exa Completed 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working dife. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) rould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1/4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental I ပ BARTON NON . Page 1 and 2 should b ment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relatio sh p (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, tate, Zip Code) lean 20a. Method of Disposition
1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o cemetery, crematory or other place 128 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility 4 9 24 YORK MONKTON MD 2/11/1 REMATIONSFRUICES 23a. Pan 1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to or as a consequence of: that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Box 68760 attending p as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day the P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown een 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 24a. Was an page 2 s has autopsy perform certificat Yes Division of Vital To the Hospital or Attending Physician: ector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 \(\text{Yes} 2 X No impertient မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specific within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) kuss K125808

DHMH 17 Rev 7/2009

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)
JUN 2 8 2011

CRNP 6701 N.Cha

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June Robert Lemuel Brooks P_{M} 9:00 26, 2017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Parkville 2404 Edgewood Avenue Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Year) 933 1 🕅 M 2 🗆 F 216-28-8544 Hours Baltimore MD **Director** 78 Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Baltimore Parkville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 2404 Edgewood Avenue 21234 United States er than "natural", or items 23 the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces?

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1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ To the Hospital or Attending Physician: The law requires that the death in the past 12 months? Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

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Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death commed at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and tipe of continer 29d. Date signed (Month, Day, Year) 137 person who completed cause of death (Item 23a) (Type, Print) 2300 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 24,^{Day}2011 Charles H. Blenkner, June 10:30P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . 1<u>923</u> 216-16-8130 1 3 M 2 F Days Months Min. Hours Director NOV. 19 87 Yrs Maryland Usual Residence of Decedent 23a or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Parkville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9943 Harford Road 21234 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, by i 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 ₩ Widowed 4 □ Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Bendix and BISM Industrial Engineer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once. ဂ္ Charles H. Blenkner Amelia Bose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Rosler-daughter 25 Winding Brook Lane-East Longmeadow, MA 01028 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Parkwood Cemetery June 28,2011 4 ☐ Donation 5 ☐ Other (Specify) Parkville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Chapel Harford Road-Par 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Physician/ Onset and Death cherce Cardioinpath disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner evonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery sate has been signed by the atte page 2 should be detached for in the past 12 months? Month Yes 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy Director: After this certificate performe Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 🗹 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? hours after death. Accident
Suicide Investigation 1 Tes 2 No Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 100 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Charles St. 20201 BMC 6701

DHMH 17 Rev 7/2009

State

Registrar

JUN 2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Helen S. Brett Physician/ Month JUNE 50 AM 25 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BAltimure Washington Medical center Anne Arunde Glen BURNIC Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, **Funeral** 264-32-8494 1 □ M 2 X 82 Director 12/29/1928 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar most han activity or other traumatic event. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 5509 Park Road Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Administrative Assistant | State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle, Maiden Surname)
Mary Hogue ည John Matthews | 19a. Informant's Name/Relationship (Type, Print) | Mary-Claire Brett/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
204 Oak Leaf Circle, Unit E, Abingdon, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 remation 3 🗀 Removal from State Final Journey Crem. 6/29/2011 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD W. Q1 augh 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phyllician/ Metastatic COLON CANCER disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🛣 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate 1 Yes 2 No To the Hospital or Attending Physician: completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 욘 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred 1 X Natural 5 Pending injury work? hours after death. Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier JUNE 25, 2011

State

17cmry

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Baltimore

Registrar's Signature

Washington Hospital Center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 10:20 pm June Loveta M. Becker Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5708 Hilltop Road Middle River Baltimore 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Min (Month, Day, Year) Country) **Director** Tenn 219-32-1542 28a-f show 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 🗌 Yes 2 🙀 No MD Baltimore <u>Middle River</u> 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 5708 Hilltop Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 Xio Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Bar Maid Bar traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file.
Department of Health and Mental Important: If item 27 is marked of any injury or other traumation. မ Jess Mosley Ruth Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Vivia L. Pollack-Daughter</u> 5716 Hilltop Road, Middle River, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery crematory or other place)
Happy Valley Mem. Burial 2 Cremation 3 Removal from State 7/01/2011 Elizabethton, 4 Donation 5 Other (Specify) Tenn. arden Name and Address of Facility Connelly Funeral Home Of Essex Signature of Funeral Service Licensee Avenue, Essex 300 Mace 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Small Cell Lin Metastatic Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and tran Due to (or as a consequence of) attending physician all for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death Unknown P.O. s been signed by the should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l page 2 s 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 🖟 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tyes 2 X No 5 Residence 6 Other (Specify မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Mann f Death funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatui June 27th 2011 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) #208, Bailinure, MD21237 31. Date filed (Month, Day, Year)

State

Registrar

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2<u>011</u> Catherine Elizabeth Beyer June 26 6:20 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rock Spring Village Forest Hill Harford Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Maryland 1 □ M 2 🛛 F (Month, Day, Year)
May 27, 1923 Director 214-22-7718 88 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The strength is marked other than "natural", or items 23a or 28a-f show lury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Colgate Drive 21050 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, δ 1 Never Married 2 Married ☐ Yes 2 🖾 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Reinholt Winskowski Litha Ann Busler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy D. Petty / Daughter 201 Reba Ct., Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1:
Department of I
Important: If it
any injury or of cemetery, crematory or other place 1 Durial 2 Cremation 3 Removal from State Hilltop Service Corp. 6-28-11 4 Donation 5 Other (Specify) Towson, Maryland 21. Signature of Funeral Service Licensee McConas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Urivary tract disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and orgestive the burial-transi Due 6 (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation, Hypertension, Hypercholeste 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Seizure Disorder, and Dementia 24a Was an page 2 performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 1 ☐ Yes 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 🗌 Yes 2 🔲 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined building, etc. (Specify) Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

gate Dr.

(0)

MD

Dr. Aly Naguib

Suite 103 Forest Hill, MD 21050

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5, per fh, g935 1-8-13 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Mariano Joseph Bonsignore 1:45 A.M. IUNE 25, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FRANKLIN SQUARE HOSPITAL BALTIMORE ROSEDALE Social Security Number 214-26-4709 212-90-8698 If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 06/01/1930 **Funeral** 7. Age (In vrs. last birthday) Months Days Hours 1⊠M 2□ Director 81 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director Maryland Baltimore 1 ☐ Yes 2 X No Essex the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ō 338 Back River Neck Road 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 ,o 1 ☐Yes 2X No δ Specify: 3 Widowed 4 Divorced White "natural" Completed marked other than "natu matic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk Painter Construction BONSIGNORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phillip Bonsignore Unknown ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25419 Anna Herbert (Daughter) 60 Morningside Drive, Falling Waters, West Virginia 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 4 Donation 5 Other (Specify) 06/28/2011 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. <u> 1407 Old Eastern Avenue, Essex, Maryland 21221</u> 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final direase or condition resulting in death)

a. CHF

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner CARDIOMYOFATHY ISCHEMIC Sequentially list conditions, if any, leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed attending physician and for use as the burial-transit COPD Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.0. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No 24a. Was an autopsy perform certificate Division of Vital 2. No 1 □Yes director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death After t 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending within 24 hours after oeau.

To the Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) JUNE 26, 2011 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUYEUNG 19000 DR. KAML FRANKLIN SQUARE DRIVE BALTIMORE MD 21237 KYN 31. Date filed (Month, Day, Year) 32. Hegistrar's Signature State JUN 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar 20462 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25^{Day} **BROOKS** Loretta 20**1**1 9:00 AM June Medical 4a. Facility Name (if not institution, give street and number) lb. City, Town, or Location of Death Rockville **Examiner** 4c. County of Death Shady Grove Adventist Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6/25/11 00900 1 🗆 M 2 👿 F 75 Months Days Apr. 23, 1936 167-28-0950 Philadelphia, PA Director Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 01 City, Town or Location 01 neyand 2 should be filed within 72 hours after death with the Maryland notified at 10d. Inside City Limits Director MD Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 20832 ò 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. In Department of Health and Mental Hygiene. In marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be. by Funeral 17721 Queen Elizabeth Dr. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Yes 2 X No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Property Manager Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Pockers Levin Elsie Brooks, 19a. Informant's Name/Relationship (Type, Print)
Debra Schupler / daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 17721 Queen Elizabeth Dr., Olney, MD 20832 20a. Method of Disposition udean Memoria I^{the} Garden JUne 28,2011 20b. Place of Disposition (Name of 20c. Location - City or Town, State
Oney, MD 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Licensee 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cardiac Acute Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated exacts) Due to (or as a consequence of): is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Vear 1 ☐ Yes 2 ₽ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ardiomyopal 24a. Was an After this certificate has autopsy performe 1 Yes 2 🗌 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 X No ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural injury 5 Pending death. ☐ Accident Investigation 24 hours after deat Funeral Director; 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Sertifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D053887 30. Name and address of person completed cause of death (Item 23a) (Type, Print) Rockville, MD ee Pani MD 9901 Medical CAr Dr 20450 31. Date filed (Month, Day, Year JUN 2 8,2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#15,18perFH, G916,6728/2011, WS
State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month $20^{
m Year}$ Bertha Breitman 8:30 P M Medical June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death National Hebrew Home of Washington Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** (Month, Day, Year) ug • 9 1904 1 ☐ M 2**X**☐ F Days Hours Min. New York 109-22-2708 **Director** 106 Aug. Usual Residence of Decedent 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Rockville 1 ☐ Yes 2 X No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral should be filed within 72 hours after death with to and Mental Hygiene.
Is marked other than "natural", or items 23a. 6121 Montrose Rd. 20852 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)Canna ဂ Adolph Morel1 Lina Hinkey-19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once. 7791 Dentzel Ct., Chesapeake Beach, MD Theodore K. Breitman / 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Demoval from State 06/28/2011 Chesapeake Crematory Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Uneral Service 22. Name and Address of Facility Rapp Funeral and Cremation Services 20910 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Advanced disease or condition resulting in death) Dementa Medical Due to (or as a consequence Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner ysician and e burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a 64 resulting in death) Last Physician/Medical Box 68760 phy IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 1 Yes 2 Unknown ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 2No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performe 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural (Month, Day, Year) 5 Pending work? 24 hours after death. Funeral Director: A 1 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D69568 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1801 E Jefferson St, Rockville, MD 20852 A. Chilakamarri MD 31. Date filed (Month, Day, Year)
JUN 2 8 2011 State 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Alcid Joseph Bedar	d amend #9813 1- For State Registrar	le Bo Maryland	Department Certificate	of Health and Menta of Death		eg. No.	1 20464
Physician/ Medical Examiner	Decedent's Name (First, Middle, Alcide	J	oseph	Bedard	2. Date of Dea Month June 22, 2	nth Day Year	3. Time of Death 2205 hrs
	4a. Facility Name (if not institution, Upper Chesapeake Med	- ,		4b. City, Town, or Location of D Bel Air	Death	4c. County of D Harford	eath
Funeral Director	014-01-5531	. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year If Under 2 Months Days Hours	8. Date of Bir Min. 9–18–	rth(MM/DD/YYYY) 9. -1920	Birthplace (State or preign Massachus Country) Marylar
daryland 28a-f show any 1at once. ector	Usual Residence of Decedent 10a. State 10b. County Md • Ha	arford	10c. City, Town or Lo	BelAir			10d. Inside City Limits 1 Yes 2 X No
ith the Maryland 23a or 28a-f sho notified at once. al Director	10e. Street and Number 808 N. Pine Ri	idge Court		10f. Zip Code 21014	1	0g. Citizen of What 0	Country?
fter death wi ", or items er must be / Funers		Armed Forces? 1 X Yes 2 ced If Yes, Give Year	Yes 2 No Yes, Give Year Dates: 1 Yes 2 No specify:			White, etc.	ite
	15. Decedent's Education (Specification Elementary/Secondary (0-12) 7 th	College (1-4 or 5-	+) during	lent's Usual Occupation (Give kin- most of working life. DO NOT us ninist	d of work done e retired)	16b. Kind of Busine	el Company
	17. Father's Name (First, Middle, La Joseph Bedard 19a. Informant's Name/Relationship		19b. Mail	Derexir	a Poitrai	İs	tate Zin Codo)
MD id 2 shoulth and in 27 is aumati	Diane Landry 20a. Method of Disposition		DTR. 80	08 N. Pine Ridge	e Court I	BelAir, Md	. 21014
imor Pages ment of tant: If	1 Burial 2 XCremation 4 Donation 5 Other Spec	cify:	e crematory or Atlantic	other place) Crematory 6	-23-2011	20c. Location - City Glen Bur	
	21. Signature of Euneral Service Lie			510 W.MacPhail	Rd. BelAi	Funeral H ir, Md. 21	
Physician /Medical Examiner	23a. Part I. Enter the disease, or co failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	a. Left Hip Fracture	he death. Do not ente	r the mode of dying, such as card ygen-dependent respirato	iac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
	Sequentially list conditions, if any, leading to immediate	Due to (or as a consect	·				
ted Insit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect c. Due to (or as a consect con					
be execution and urial - tra	UNPENDED	dAMENDED			_		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	23c. If yes, outcome 1 Live birth 4 Pregnant at til	2 1	Fetal death 3 Ectopic pro	egnancy	23d. Date of delive Month	Day Year
P.O. Boston that the degree of the detached of the detached of the by the by Phy	Part II. Other significant condition	9 Unknown	but not resulting in the	e underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Records, P.C. The law requires that are has been signed age 2 should be deta	Renal disease				24a. Was a	an 24b. Were	robably 4 V Unknown autopsy findings available
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the stafter death. al Director. After this certificate has been signed by led in by the funeral director, page 2 should be detacted by Terrification: To Be Completed by P	25. Was case referred to medical	1		26.Place of Death (Ch		med? death	o completion of cause of ? Yes 2 No
f Vital I Physician: ar this certifi	examiner?	Hospital: 1 Inpatient		nt 3 DOA Other No	ursing Home 5		her:
Division of spiral or Attending P spiral or Attending P nours after death. neral Director: After filled in by the funerat Certification:	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investig	ation	0000 hrs	1 Yes 2 ✔ No	Subject fell	now injury occurred	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the edical Certification	3 Suicide 6 Could n 4 Homicide determine 29a. Certifier	ned (Specify) Nurs	ing Home	eet, factory, office building, etc.	or Town, St 1915 Rock Sp	tate) ring Road, Forest l	
To the Howithin 24 b To the Furcompletely	(Check only 1 Certifying Phys	ician: To the best of my liner: On the basis of exami and manner stated	knowledge, death occ nation and/or investig	urred at the time, date and place, ation, in my opinion, death occurr	and due to the cause ed at the time, date a	and place, and due to	the cause(s)
	and 2			29c. License number O.C.M.E.		29d. Date signed (I	Month, Day, Year)
		ant Medical Examir	ner 900 W. Ba	Itimore Street, Baltimore,	MD 21223		
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's	Signature				

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Burse Month 18:45 srace 201 Medical 06 Examiner 4a. Facility Name (if not institution. give street and number 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Ctr Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Months Director April Day Yer931 218-26-9220 80 Mary land Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 XNo Md. Harford Abingdon ō 10e. Street and Number 10f. Zip Code must be 10g. Citizen of What Country? Funeral **23**a 3817 A. Memory Lane 21009 USA items ? Page 1 and 2 should be filed within 72 hours after death in the 1 health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ò δ 1 Never Married 2 Married Black, White, etc. 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 x No Specify "natural" Completed 3 XWidowed 4 Divorced Specify: White Year or Dates er than "natur the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Financial Adminstrator Towson University item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Huber Emma Traeger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR <u>Linda</u>Beall 8403 Glen Road Parkville, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State 1 💹 Burial 2 🗆 Cremation 3 🗔 Removal from State 4 Donation 5 Other (Specify) 6-27-2011 Garrison Forest Owings Mills, Md. Schature of Funeral Service License 22. Name and Address of Facility Schimunek Funeral Home <u>9705 Belair Road</u> Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death APPROVED BY MEDICAL EXAMINES Immediate Cause (Final Mul tiple Ph sician/ Enjur disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Saquer ttally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events VEL Examine Due to (or as a consequence of): burial-trans and resulting in death) Last Due to (or as a consequence of) iding physiciar Physician/Medical that the death certificate be Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant atten 23d. Date of delivery Por in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Pregnant at time of death Month Day detached 1 the 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes 2 \(\sum \) No ate has bage 2 s 24a. Was an autopsy perform certificate 1 Yes 2 No or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA this ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) n 24 hours after death. e Funeral Director: After th bleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Investigation 06 06 2011 13:26 1 \square Yes Suicide 6 Could not be lace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)
R. + 914 at R+14 Abindon, Mi determined Roodway Hospital Medical 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2011 Name and address erson who completed cause of death (Item 23a) (Type, Print) Greene St. Balhmore my MI 29 South avid 31. Date filed (Month, Day 32. Registrar's Signature State JUN 2 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Barbara Blasy ♠ Month 30 a.M 101 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death St. Elizabeth's Nursing Home Baltimore N/A 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days Hours Min. Oct. 25, 1922 214-30-6548 88 Hungary Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10a, Citizen of What Country? 1956 Bell Avenue 21227 United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 ☐XNo Specify. 3 X Widowed 4 Divorced White Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 5 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franz Payer Barbara Sauter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Simon Payer - Brother 11 Clay Lodge Lane #403, Catonsville, MD 21228 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Medaceria (volother place)
Memorial Park 1 Aurial 2 Cremation 3 Removal from State 4 Denation 5 Other (Specify) 6-28-2011 Elkridge, MD of Funeral Service Licerts 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur SPring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line rval Between set and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Accident Investigation M 1 Yes 2 No

sician and burial-transit attending physician for use as the buria Division of Vital Records, P.O. Box 68760 detached for the signed by page 2 should has certificate Hospital or Attending Physician: this After t Director: /

Physician/

Medical

Examiner

Funeral

Director

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items 23a

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permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once,

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Medical

4 Homicide

Examiner

Page 1 and 2 should be filed in the Page 1 and Mental Hyon

within 72 hours after "natural",

男/ルプケール したい Baltimore, Maryland 21215-0036

Examiner must be notified at

the Medical

Director

Funeral

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Completed

Be

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thin 24 hours after de the Funeral Directo impleted filled in by the

10 V

building, etc. (Specify)	City or Town, State)
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and the death occurred at the time, date and place are the death occurred at the time, date and place are the death occurred at the time, date and place are the death occurred at the time, date and place are the death occurred at the time, date and place are the death occurred at the time, date and place are the death occurred at the time, date and place are the death occurred at the time, date and place are the death occurred at the time, date and place are the death occurred at the time, date and place are the death occurred at the time, date are the death occurred at the time, date are the death occurred at the time, date are the death occurred at the time, date are the death occurred at the death occurred at the time, date are the death occurred at the death occurred at the death occurred at the death occurred at the death occurred at the death occurred at the	at the time, date and place, and due to the cause(s) and manner stated
29b. Signature and title of certifler 29c. License number 25 7 7 9	29d. Date signed (Month, Day, Year) New 24, 2011
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 41 44 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	willow besting

28f. Location (Street and Number or Rural Route Number.

6 Could not be

determined

31. Date filed (Month, Day, Year)

State Registrar 28e. Place of Injury - At home, farm, street, factory, office

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BHASKAR 1855PM TUNE 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY OLNEY MONTGOMERY HOSPITAL GENERAL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year January 5, 1 g. Birthplace (State or Foreign Country) India Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 😿 M 2 🗆 F Director 72 579-64-8997 Usual Residence of Decedent show ms 23a or 28a-f shormust be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Silver Spring Maryland Montgomery 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral United States 20905 15205 Aylesbury Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: Asian, Indian Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Flementary/Seconday (0-12) College (1-4 or 5+) event, the Auto Ith and Mental Hygien 27 is marked other the traumatic event, the Sales Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ္ Kishan Devi Sadhu Ram Bhaskar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 7203 Sheehan Court, Derwood, Maryland 20855 Vaneet Bhaskar/Son Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c Location - City or Town State June 23, cemetery, crematory or other place)
West Arundel
Crematory 1 Durial 2 🙀 Cremation 3 D Removal from State Important: If any injury or once, 4 Donation 5 Other (Specify) 2011 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21 Signature of Funeral Service Licensee M01386 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ISCHEMIC CARDIOMYOPATHY disease or condition resulting in death) Medical Examiner CORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last physician and the burial-tran Due to (or as a consequence of): Completed by Physician/Medical Box 68760 as IF FEMA! F 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? FIBRILLATION ATRIAL 24a. Was an autopsy performed? Yes 2 has DIABETES 2 No 1 Yes Division of Vital сотрыете filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 1 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural 5 Pending death. 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) prewreder, MD D59418 JUNE 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DV ADEWUNMI, MD MONTGOMERY GENERAL HOSPITAL

DHMH 17 Rev 7/2009

State Registrar

OLUYEMIS 31. Date filed (Month, Day, Year) 11-04736 Michael Brooks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day June 25, 2011 Michael Brooks **Medical Examiner** 1210 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital **Baltimore Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs, 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign MD Country) 220-45-1195 02/01/1996 Months Hours Director 15 1X M 2 F Yrs Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Baltimore MD Baltimore 1 Yes 2 No 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Meral Hygiene.

other traumatie are the first of the Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2810 Oak Grove Ave. 21227 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' White, etc. 1 XX Never Married 2 Married Black Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2X No specify: Specify: or Date: 16a. Decedent's Usual Dccupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Student. 10 17. Fether's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Michael D. Brooks Sheila M. Horn Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2810 Oak Grove Ave., Baltimore, MD 21227 Jean Horn / Grandmother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Loudon Park Cemetery 1 X Burial 2 Cremation 3 Removal from State partment o. Important: Il 07/01/2011 Baltimore, MD 4 Donation 5 Other Specify 22. Name and Address of Facility Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 21. Signature of Funeral Service Licensee M01452 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical a. Gunshot Wound of Head Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and ed for use as the burial - transit cian/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown detached Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? ✓ Yes 2 No certificate 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 🗸 Inpatient 2 🗌 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes 2 No 28a. Date of Injury (Month Day Year) Jun 25, 2011 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject shot Natural 1127 hrs 1 Yes 2 ✓ No 5 Pending To the Funeral Director: Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide 6 Could not be or Town, State) 2463 Seamon Ave, Baltimore, MD (Specify) 4 Momicide Rowhouse 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E June 26, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD State Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ STEVEN STUART JUNE 7:58 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE N/ASocial Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Director 215-54-4501 1177571949 Yrs. 61 MD Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Tes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number diversity Hygiene. marked other than "natural", or items 23a or marked other than "natural", or items 23a or matic event, the Medical Examiner must be a 10g, Citizen of What Country? Funeral 206 SUDBROOK LANE 21208 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2X Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed WHITE 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) JEWELER JEWELRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) age 1 and 2 should be filent of Health and Mental ort. If item 27 is marked y or other traumatic ev ည BURTON BLUM MILDRED STARK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERRY BLUM/WIFE 206 SUDBROOK LANE, BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/26/2011 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ARREST CARDIAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner OVERWHELMING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that imitiated events and interest that in the cause of the cause Exami RUPTURED DIVERTIQUITS المحدكس and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death the Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 🗌 No 1 🗌 Yes 2 🔽 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 1 Inpatient Other: 은 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury s after death.

I Director: Af in by the fur Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours after Funeral Direct leted filled in b City or Town, State, Medical 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

4 HOURS Box 68760 P.O. Records, Division of Vital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ATZ438946-49 23 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & UNIVERSITY PKNY, 21218 201 31. Date filed (Month, Day, Year) State 28 Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 12:20 PM GUSTAVE **JACOB** BENZION JUNE 25 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examine COLLINGSWOOD NURSING & REHABILITATION ROCKVILLE MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Months Hours 88 Yrs. Director 217-16-7085 04/20/1923 MD Usual Residence of Decedent death with the Maryland 10a. State 10h County 10d. Inside Cify Limits 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No Director MD MONTGOMERY GAITHERSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7534 ELIOAK TERRACE 20879 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examine and. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: WHITE Specify þ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE CARBONIC 8 OWNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ WOLF BENZION CLARA FLASHNER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRA BENZION/SON 7534 ELIOAK TERRACE, GAITHERSBURG, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place)
MIKRO KODESH
BETH ISRAEL CONG. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/27/2011 BALTIMORE, MD 21. Signature of F yeral Service big 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami burial-tra Due to (or as a consequence of): physician the burial P.O. Box 68760 Physician/Medical ed by the attending property detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown signed by 1 Part II. Other significant conditions pontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown page 2 should Completed been : 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? certificate or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 ₩o 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital

State Registrar

31. Date filed (Month, Day, Year) JUN 28 201

Collingswood

29b. Signature and title of certifie



and manner stated.

and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June Pearl Thompson Counts 2011 4:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Asbury Solomons Sol<u>omons</u> Calvert 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Country) Minnesota **Funeral** 8. Date of Birth 469-20-0725 Months Hours June 28 1 □ M 2🏋 F Year 1923 Director 88 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Me Jical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Calvert Solomons 1 Tes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 11100 Asbury Circle 20688 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force . or Black, White, etc 1 Never Married 2 Married Completed by Yes Baltimore, Maryland 21215-0036 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 □ Divorced Specify: Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry Carl Thompson Clara Amanda Easton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven L. Counts / Son 10291 Carnegie Club Dr., Collierville, TN 38017 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Metro Crematory Inc. 106/28/2011 Baltimore, Maryland Signature of Funeral Service Licensee Alyson K 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ DUNNOUZX disease or condition resulting in death) Medical Due to (or all a consequence of) Examiner scor ovasculas Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year the g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? performed this certificate 1 Tes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Assisted မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury 5 Pending work?
1 Yes 2 No Acciden Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ONGJIN 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul V. Pomilla, M.D., 110 Hospital Rd., Suite 310,, Prince Frederick, MD 20678

X DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Phiistrar

11-04040 Jack Clark Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ack Clark		1- For State Registrar	ate of Maryla		artment of rtificate of		and M	/lental H	F	Reg. No.	201	1 20472
Physic dedical Exam		Decedent's Name (First, Midd Jack Clark	le,Last)						2. Date of De Month May 30, 2	Day	Year	3. Time of Death 1200 hrs
		4a. Facility Name (if not institution 4 Upland Road	4b. City, Town, Baltimore		ation of Death			County of Dea	ath			
Funeral Director		5. Social Security Number unk	6. Sex	7. Age (In yrs. I 73			_	Under 24Hrs Hours Min.	_	•	For	Birthplace (State or Unk eign Country)
any		Usual Residence of Decedent 10a. State 10b. County		10c. Cify	, Town or Locati	on						10d. Inside City Limits
E		MD		В	altimor	e						1 X Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	10e. Street and Number		•		10f, Zip Code	Э			10g. Citiz	en of What Co	ountry?
ith the 23a o	a D	4 Upland Road		edent Ever in U	S 13 Wa	212		ic Origin2 / Sr	pecify Yes or N	US		erican Indian, Black,
fter death ", or iter	Fune	1 Never Married 2 M		rces? unk 2 No	If Y	es, specify Cul	oan, Me	xican, Puerto	Rican, etc.)		White, etc.	
hours a	ed by	15. Decedent's Education (Spe	cify only highest grad			t's Usual Occu				K 16b, Ki	nd of Busines	s/IndustryUNK
36 nin 72 e. than "	Completed	Elementary/Secondary (0-12) unk	College (1-	_ '		-			ŕ			
21215-0036 wild be filed within 72 hours a Mental Hygiene. marked other than "natura ic event, the Medical Examin		17. Father's Name (First, Middle			<u> </u>		18.M	lother's Name	(First, Middle,	Maiden S	Gurname) UI	ik
	To Be	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailing	Address (St	reet and	d Number or F	Rural Route Nu	ımber, Cit	y or Town, Sta	ite, Zip Code)
Baltimore, MD 2's permit. Pages 1 and 2 should Department of Health and Mill Important: If item 27 is mainjury or other traumatic e-		O.C.M.E.		Tool								land 21223
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		30. Name and address of person	who completed cause Assistant Medica			oltimers Ct	roct 5	Paltimore	MD 24222	1	-	
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Ponis		31. Date filed (Month, Day Year)	11 /2	VB.	Harris							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ONNELL Month Year 8155 TWIF 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10 N. ST. AUGUSTINE hesapeake EC Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 07/07/ Months 213-52-5145 64 Director NJUsual Residence of Decedent show 10a. State ould be filed within 72 hours after death with the Maryland to Mental Hygiene.
marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f shor Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Cecil Chesapeake City Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 North St. Augustine Road 21915 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Completed by Black, White, etc. 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 White If Yes, Give 1 Yes 2 XNo Specify: 3 ☐ Widowed 4 🏿 Divorced Specify: Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Assistant</u> Healthcare Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname)
Ruth Reynolds 17. Father's Name (First, Middle, Last) ည Connell James 19a. Informant's Name/Relationship (Type, Print)
Jessica Martin /Daughter 9b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Buttonwoods Rd., Elkton, MD 21921 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crem. 6/28/2011 Woodbine, MD 21. Signature of Formeral Service License Dorrota Marshall 22. Name and Address of Facility Services Maryland PO Box 1 remation 3. Balti 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Cancer disease or condition resulting in death) Uterine Medical Due to (or as a consequence of): ^{*}Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burial-1 physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Year Pregnant at time of death Day detached 9 Unknown 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed certificate completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MSREGED ANEM'D D0057465

State Registrar

DHMH 17 Rev 7/2009

2835

32. Registrar's Signature

Smon AN S-203 Baltimor, MD 21209.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakse, M.D.

IIIN 2 8 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Deeedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 25^{bay} 2011 11:46P M evern Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAINT JOSEPH MEDICAL CENTER BALTIMORE TOWSON If Under 1 Year | If Under 24 Hrs. 5. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F (Month, Day, Country) Director Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Baltimore MO 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 27 is marked other than "natural", or items 23a on raumatic event, the Medical Examiner must be a Funeral 5109 Laurel Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: Back 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore (leacher St Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Jackso avid leanors. permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimone MD 21209 (Daughter 2459 Forest Green Road Maria 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
alvany Baptist Church Cem 1 Burial 2 Cremation 3 Removal from State Saluda, VA 2011 07/02 4 Donation 5 Other (Specify) Vaughn C. Greene Fineral Services 22. Name and Address of Facility 21. Signature of Funeral Service Licensee augh Randallstown MD 21133 Read 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause #final disease or condition. Interval Between Onset and Death Physician/ SEPTIC SHOCK disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ISCHEMIC BOWEL Sequentially list conditions, if any, leading to mediate cause. Enter Uniting Examine Due to (or as a consequence of): Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ACUTE ON CHRONIC RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No URINARY TRACT INFECTION 24a, Was an autopsy perform has page 2 Yes 2 N this certificate 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: 1 Yes ျ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of the funeral 28c. Injury at work? 1 \(\text{Yes} \) 2 \(\text{No} \) Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Hospital Medical 29a. Certifier 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and 29c. License number 29d Date signed (Month, Day, Year) D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY LOW M.D. 7601 OSLER DRIVE TOWSON, MD 21204

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bentha -- Month Day 7:25 PM Castee 25 عبرر 2011 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4ç. County of Death Hespita nba Howard Genera 010-Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days Months Hours Min July 14, 1921 1 □ M 2 🖵 F 218-14-8079 Director 89 Mary land Usual Residence of Decedent show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2X No MD Howard Fulton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11805 Wayneridge Street 20759 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 No Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker/Sales Own Home/ Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be John Reichert Bertie Steq 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David O. Casteel/son 2128 Stone Pine Drive Las Cruces, NM 88012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) John's Cemetery 06/29/2011 Ellicott City, MD Signature of Funeral Service License 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc uanta (k thomas M00957 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Prevmonia Onset and Death Physician/ ZWEEKS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ra ly, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a coll segue, by of, Exami that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burial attending physician for use as the burial Physician/Medical Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death the detached g 🗌 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵| Division of Vital Records, or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a. Was an has autopsy performed certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Impatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 🖹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number D46120

DHMH 17 Rev 7/2009

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Do

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charten

32. Registrar's Signature

10710

relem

JUN 2 8 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G916 6/28/2011 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2011 Physician/ ANTHONY CORUZZI JUNE 23 2:28 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1504 CHESACO AVENUE ROSEDALE BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 218-58-6407 1 🔀 M 2 🗆 F 61 Months Hours Min. (Month, Day Year) 949 CTTALY Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ROSEDALE MD BALTIMORE 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1504 CHESACO AVENUE 21237 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 Widowed 4 Divorced Completed Year or Dates marked other than "natur matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 DISABLED DISABLED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည JACINTO CORUZZI ROSA NORI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1200 BROOKVIEW ROAD TOWSON, MD 21286 19a. Informant's Name/Relationship (Type, Print) PETER CORUZZI/BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place)
DULANEY VALLEY 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 KBurial 2 Cremation 3 Removal from State 6/27/11 TIMONIUM, MD 4 Donation 5 Other (Specify) vice Licenses 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock Physician/ disease or condition resulting in death) Medical Due to or as a consequence of): **Examiner** days reled color Sequentially list conditions. Examine if any, leading to immediate
Cause (Disease or iinjury as a consequence of): 20 403 law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Yes 2 No g Unknown g Unknown the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv perform Hospital or Attending Physician: The 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Presidence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) D43936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Thomas F. Lansdale (II M.D. 6535 N. challer St. 132 (Illimore Mi) Lansdale 31. Date filed (Month, Day, JUN 2 Š State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G916, 6/28/2011, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Paul Year (RIS na 551 Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F Months Days Hours Min. July 19 Year 1961 220-82-1244 50 Maryland Director Usual Residence of Decedent 28a-f shov ms 23a or 28a-f shormust be notified at 10a. State with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Howard 1 🗆 Yes 2 No Jessup 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 7958 Washington Blvd. 20794 United States items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give "natural", or \$ 1 Never Married 2 X Married Black White etc. Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Specify. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HVAC Sheet Metal Foreman traumatic event, Be filed permit. Page 1 and 2 should be flex
Department of Health and Mental H
Important: If item 27 is marked oft
any injury or other from: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carl Cessna Rosalie Jenowick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tina Cessna - Wife 7958 Washington Blvd., Jessup, MD 20794 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 M gurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) John's Cemetery 4 Donation 5 Other (Specify) 6-27-2011 Ellicott City, MD Signature of Functal Service Lie 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death meningitis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No for Month should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ preumonica 1 Yes 2 No 3 Probably 4 Unknown Completed myocardial inforct 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform Yes 2 No 1 Yes funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20066515 23 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V Nishi Rawat 10710 Charter Drive St. 310 Columbia, Md 21044 31. Date filed (Month 32. Registrar's Signature State Registrar

State Registrar

31. Date filed (Month, Day, JUN 2 8 2011

29b. Signature

and title of certifier

SATULISNE. D'AMOND

2835 Smith Dumus BALTIMONE, MARY/AND 21209 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

R088852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Charles Brian Davison 6.40 22 2011 une /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SALTIMORE HGR IES N/A 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral ¼** M 2□ F Days Months Hours Yrs Director 218-72-7298 52 12-10-1958 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Pages 1 and 2 should be filed within 72 hours after death with 2112 Stonewall Road or items 23a 21228 Funeral United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married X Married altimore, Maryland 21215-0036 1 ☐ Yes Z☐ No Specify. þ WHITE Specify: 3 Widowed 4 Divorced "natural" Completed d other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) v.27 Is marked other than "r traumatic event" Elementary/Secondary (0-12) College (1-4or 5+) 2 years Budget Analyst Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rex Davison ၉ Lola Meyers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Kathleen B. Davison - WIFE 2112 Stonewall Road, Baltimore, MD 21228 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ţ Department of Important: If it any injury or conce. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory INC : 06-24-2011 | Baltimore, Maryland Funeral Service Licensee Patrik Fleming 22. Name and Address of Facility Cremation Society Of Maryland INC 299 Frederick Road, Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition MINUtas resulting in death) // /Medical Due to (or as a consequence of): Examiner THEROSCIErosi E adjustant list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the cauthous indexts) Due to (or as a consequence of): burial-trar resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical e esn IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No autopsy 2 No 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Nes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending Natural 5 Pending death. investigation 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 🗌 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton AVE BALTIMORE, Md. 21829 Mee State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylan		artment of		and M	lental Hy	giene	Market Street	20480		
			Registrar Certificate o 1. Decedent's Name (First, Middle, Last)						neg. No						
	Physicia		RITA	SKI	Mont			2. Date of De Month	Day 24	2011	3. Time of Death 00:03 M				
ye ba	Medic Examin		4a. Facility Name (if not institution	or Location	of Death	OUNE		nty of Death							
-	<i>*</i>		UNIVERSITY OF MI				BAZ	TIMOR	-E						
	Funeral Director		5. Social Security Number 216-38-3051	6. Sex 1 ☐ M 2 🔀 F	Age (In yrs. Ia 70	ast birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Bird (Month, Da DeC • 16		9. Birthp Coun	olace (State or Foreign try) Maryland		
			Usual Residence of Decedent							DCC. I(1940		Paryland		
	yland -f sho ed at	ctor	10a. State 10b. County		10c. City	y, Town or Lo	cation					1	0d. Inside City Limits		
	e Mar r 28a notifi	Director	Maryland Harf 10e. Street and Number	ord	Ede	gewood							1 Yes 2 No		
	vith th 23a o st be		926 Olive Bran	och Court No	n rt h		10f. Zip Code 21040				10g. Citizen o		try?		
	eath v tems er mu	Completed by Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S		Vas Decedent of I	Hispanic Ori	igin? (Spe	cify Yes or No-		ace - Americ	an Indian,		
36	ifter d ", or i amin		1 Never Married 2 Mar	If Voc Cive			f Yes, specify Cub □ Yes 2 🕱 No			Rican, etc.)	1	lack, White,	etc.		
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Maryland 21215-0036	e filed tal Hy ed oth even		17. Father's Name (First, Middle, L							(First, Middle,		me)			
Ĕ	d Mer d Mer mark matic		Francis Peter I 19a. Informant's Name/Relationsh			T		-		Rita C					
Σ	12 should all the and 27 is r trau		Tina Marie Hoch		r	1	g Address (Street Towne Ce						iode)		
re,	1 and of Hea		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other pla			ate	20c. Location		wn, State		
<u>m</u>	Page ment cant: If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			-	Memorial		6-2	3 - 11	Parkv	ille.	Maryland		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature: Funeral Service L	icensee			Name and Addr CCOMAS F 317 Coke								
П			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caus	sed the death	n. Do not ente	r the mode of dyi	ng, such as	cardiac or	respiratory arr	est,	2100.	Approximate		
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	Medical Examiner		resulting in death)	Due to (or a	s a consequ	ence of):	TIVE ST								
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760	cate b physi s the b	edical		d											
(687	requires that the death certifics been signed by the attending p should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnar		F-4				23d. [Date of delive	ry		
P.O. Box	death he atte ed for	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnan	at time of de		Ectopic pregnan Other (specify)	су		17			· · · · · · · · · · · · · · · · · · ·		
o.	at the d by tl letach		9 Unknown Part II. Other significant conditio			ulting in the ur	nderlying cause di	ven in Part	1	220 Did to	haaaa 1130 aa	ntributo to th	e cause of death?		
	ires th signe Id be c	d by					,g g.				res 2 □ No		ably 4 Unknown		
ord	v requ	olete								24a. Was a	ın 24b	o. Were autop	sy findings available		
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ā	sician: The certificate rector, pag		25. Was case referred to medical examiner?	The state of			26. P	lace of Deat	th (Check		2,02410				
<u>=</u>	Physia this c	<u>٩</u>	1 Yes 2 No 27. Manner of Death			ER/Outpatient		4 🗀 Nu		ne 5 🗌 Resid					
0 0	nding Ith. : After s funer	Certificate:	1 Natural 5 Pending		ay, Year)	injury	28c. Injur worl M 1	yat k? !Yes 2 □		8d. Describe h	ow injury occu	rred			
ISIC	• Atter er dea ector by the	ertifi	3 Suicide 6 Could r	Injury - At home, farm, street, factory, office 28f. L						f. Location (Street and Number or Rural Route Number,					
2	ital or urs aft ral Dir lled in		building, etc. (Specify) City or Town, State)												
	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 L Medical E	Physician: To the best of xaminer: On the basis of Nurse Practioner: To the	examination	and/or investi	gation, in my opini	on, death oc	curred at t	he time, date ar	nd place, and d	lue to the cau	se(s) and manner stated. i		
	vithi Com	_	29b. Signature and title ocertifier	1/1			29c. Licens	e number			29d. Date signed (Month, Day, Year)				
			Mas Kity, no P24346 June 24, 2011									2011			
V			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KCLTZ WWENSMY IF MANYUMD MEDIUM COWNER; 22 SOLU CAMES. BRELIMONE, N.D. 2120)												
	Stat Registra	-	31. Date filed (Month, Day, Year)		trar's Signatu										
				COTO	_	- /									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHARITY MAY ELEK Month 9:55 Medical June 24 Α 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 298 Woodglen Place Pasadena Anne Arundel **Funeral** Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Oct 2, 19 9. Birthplace (State or Foreign 1 □ M 2 🕅 F Months Days Hours Min. 214-38-8409 West Virginia **Director** Yrs. 69 1941 Usual Residence of Decedent shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Pasadena Anne Arundel Maryland 1 🗆 Yes 2 😾 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 298 Woodglen Place 21122 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates "natural". 1 Tes 2 No Specify. 3 X Widowed 4 Divorced Completed White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Should be mad Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Mother Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Richard Huffman Page 1 and 2 should be Virginia Moricle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Ann Rinehart-Zick 1620 Braid Hills Dr., Pasadena, Md. (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 28, 2011 Cedar Hill Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Metastatic Onset and Death Snysician/ 10,000 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Bracot Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? ours after death.

eral Director. After this certificate I filled in by the funeral director, page perform Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 🔣 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury ☐ Accide*n*t ☐ Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number DS1596 June 24. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnic MD 2 1061 Road Ambalavanor 845 Oak wood 103 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ J\m\e 26ª Joan 20ÏĨ Epp 6:00am M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carrol1 5626 Mineral Hill Road Sykesville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar 8, 1939 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Birthpi Country) MD 1 M 2 XF Days Months Hours 72 **Director** 220-36-2589 Usual Residence of Decedent 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Carroll Sykesville 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5626 Mineral Hill Road 21784 USA items ; 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō 1 Never Married 2 Narried hours after Completed by ☐ Yes 2 🌠 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. White "natural", 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 72 (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gerard William Campbell Loretta Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trac Mr. Martin S. Epp (Spouse) 5626 Mineral Hill Road Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/29/2011 4 Donation 5 Other (Specify) Holy Family Cemetery Randallstown, MD Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 MO0 764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on, ach line. Approximate Interval Between Immediate Cause (Final Onset and Death KTERIUSCLEROTIC CALDIUNASCULON Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 9 Unknown Year Other (specify) the 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ana title of ertifier 29b. Signatur nse number 29d. Date signed (Month, Day, Year) LEVALL address of person who completed cause of death (Item 10 esinoss 32. Registrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ David A. Fritsch Month Day Year 11:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 812 Martin Road Baltimore Essex 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Year) 956 1**火** M 2 □ F oct. 5 Months Days Hours MD MD Director 219-66-7385 54 Yrs Usual Residence of Deceden ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 Yes 2 X No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 812 Martin Road USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Chief Engineer Hilton Garden Inn 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Calvin J. Fritsch Shirley A. Groat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Marie E. Thompson-fiancee 812 Martin Road, Essex, Maryland 21221 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1
Department of
Important: If it
any injury or o 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 6/27/11 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave.Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical cours resulting in death) ue to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day detached g Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 1 1 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has Hospital or Attending Physician: The After this certificate performe death? Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No ည Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Vatural 5 Pending injury work? after death 1 Yes 2 No Accident Investigation the Funeral Dire. Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the F

complete 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cel 29d. Date signed (Month, Day, Year) June 58m 15546 ompleted cause of death (Item 23a) (Type, Print) 5601 Blud

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

2 8 Loch

. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 201.81 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year FOOR ENDRA 3. 50 PM Medical 06 20 4a. Facility Name (if not institution, give street and number, **Examiner** b. City, Town, or Location of Death Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number 7. Age (In yrs. last birthday) 42 yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 213-78-0349 1 🗆 M 2×🗀 F Months Hours 04/20/1969 Director IL Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland at 10c. City, Town or Location Director 10d. Inside City Limits notified MD Anne Arundel Annapolis 1 Yes 2 X No 10g. Citizen of What Country USA 10e. Street and Number ò 10f. Zip Code "natural", or items 23a or permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must by eines. Funeral 1728 Roydon Trail 21401 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 XNever Married 2 Married Black, White, etc. Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White 3 Divorced 4 Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Kenneth Foor Sherry Walling 19a. Informant's Name/Relationship (Type, Print) 19a. Informant's Name/Relationship (Type, Print)

Kenneth L. Foor, Jr./Father 1728 Roydon Trail, Annapolis, MD 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey crem. 6/29/2011 Woodbine, MD of Funeral Service Licensed Dorota Marshal 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD a leastra 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard failure. List only one cause on each line. 21203 Baltimore, Interval Between Immediate Cause (Final Physician. Onset and Death Due to (4 s a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death). Lect Examine Due to or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed bunial-transi and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown s peen si 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s autopsy tor: After this certificate the funeral director, pag 1 ☐ Yes 2 🗷 No 2 🗷 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No ၉ Other: 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending injury Accident 1 🗌 Yes 2 No after death Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a Funeral L Medical ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completed fi 29a. Certifier (Check 2 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Own 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkway, KHAWAJA-A-FAROOD Medica 31. Date filed (Month, Day, Year, State JUN 28 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 11685 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20^{Year} Frederick Ernest Fischer III June Medical 6:36 a^M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 111 Norman Road Pasadena Anne Arundel Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpiac Country) MD 1 **X** M 2 □ F 01/12/1961 Director Yrs 212-88-8692 50 items 23a or 28a-f show 10a. State 10b. County death with the Maryland Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Pasadena ¹X☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 111 Norman Road 21122 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. P Completed by permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Operation Support Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carl F. Fischer Jr. Noreen Keckan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Lynn Fischer / Wife Pasadena, MD 21122 111 Norman Road 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 6/24/2011 Woodbine, MD of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services Dorota Marshall land P.O. Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final enset and Death Physician/ disease or condition m05. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 🗌 Yes Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 🗌 Yes 2 within 24 hours after death. To the Funeral Director: After this 1 Inpatient , 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. Lic se numbei igned (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Śigp State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day}011 Caroline Anna June 26. Ford Medical 1:09 РМ 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 961 Martin Road Essex Baltimore **Funeral** . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Days 169-16-9345 Months Hours Min. 04/05/1922 **Director** 89 Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Essex 1 Yes 2 X No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must b 961 Martin Road 21221 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Ves 2 No 1945.

If Yes, Give

Year or Dates. 1946 Black, White, etc. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Specify. 1946 White Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 10 College (1-4 or 5+) Human Resources Auto Parts Supplier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Elmer Hoffman Katie Blum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Bell (Daughter) 314 Walgrove Road, Reisterstown, Maryland 21136 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 200. Place of Disposition (Name of cemetery, crematory or other place)

Balto. Nat'l Cemetery 06/29/2011 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, Maryland 21. Signature of Fu 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. Old Fastern Avenue, Essex, Maryalnd 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line.

I mediate Cause (Final resease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Physician/ Onset and Death Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence or, if any leading to inmediate cause. Enter Underlying Exam burial-trans Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 X No
9 ☐ Unknown 4 Pregnant at time of death Month Dav Year the 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? cate has b page 2 sl 24a. Was an autopsy Hospital or Attending Physician: The this certificate 1 Yes 2 No Yes 2 No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at After 28d. Describe how injury occurred s after dea... ral Director, Aftr 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed within 2 To the F only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 Date filed (Month, Day, State 32. Registrar's Signature Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month , Thomas F. Farley Physician/ 0753 Medical as 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Horpital Baltimore N/A Social Security Number **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 XXM 2 □ F Days Hours Feb 18, 1915 Country) Director 218-10-1723 96 Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ems 23a or 28a-f sh r must be notified a MD N/A XX Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 429 West 23rd Street ral", or items ? Examiner mus 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forc 1 Never Married 2 Married Yes 2 XXNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates "natural". 1 Tes 2 Tylo Specify: Specify: White 3 ₩Widowed 4 □ Divorced if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Bethleham Steel 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Thomas Christopher Farley Florence Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dianna Shade (daughter) 435 W. 23rd St, Baltimore, MD 21211 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Department of H Important: If ite any injury or otl 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery July 5, 2011 Freeland, Maryland 21. Signator of Fundal Sorvice Licensee 22. Name and Address of Facility 3631 Falls Rd, Baltimore, MD 21211 Burgee-Henss-Seitz Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (o) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) 23d. Date of delivery Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Yes 2 No the 9 Unknown Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 s 24a. Was an autopsy perform Yes 2 No 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Yes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie DW5545

State

Registrar

Union Memorial

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Buchman

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31. Date led (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 19, Joan M. Fargo 2011 9:26 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 6110 Temple Street Bethesda Montgomery Social Security Numbe **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days Hours November 16, 129-26-0117 **Director** 78 New York Yrs 1932 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland | Montgomery 1 Yes 2 X No Bethesda 10e. Street and Number ö must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 6110 Temple Street 20817 United States items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify: White Completed 3 ☒ Widowed 4 ☐ Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Nursing Nursing Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Godfried van Lier Teresa O'Hara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Mary Beth Fargo/Daughter 2705 W. Ox Road, Herndon, Virginia 20171 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20c. Location - City or Town, State Department of Important: If it any injury or o June 24, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Silver Spring, Maryland 2011 permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase Inc. 755/ Wisconsin Avenue Bethesda-Chevy Cha Chase 208 Loy M01498 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Uremia Medical resulting in death) Due to (or as a consequence of): Examiner Ureteral Obstruction Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Congestive Heart Failure and Due to (or as a consequence of): attending physician Physician/Medical Uterine Malignancy P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 X No
9 Unknown jo Month Day Year the g Unknown Hospital or Attending Physician: The law requires that the signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performe 1 Yes 2 X No 1 ☐ Yes 2 ☐ No certific 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 X No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 5 Pending 1 X Natural injury work? 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: Ai

mpleted filled in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2.

To the F

complet only or 29b. Signa 29d. Date signed (Month, Day, Year)

Registrar

625 Wisconsin Avenue, #101, Bethesda, Maryland 20814 32. Registrar's Sinature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Collin Cullen, MD

MD0052247

June 21, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 2011 12:30P MILDRED FISCHEL Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner MONTGOMERY LANDOW HOUSE ASSISTED LIVING ROCKVILLE If Under 1 If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 M 2 X F Months Days Hours Min. 11/17/1920 Yrs Director 055-12-9607 90 NY Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 X No MD MONTGOMERY ROCKVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 9 ra!", or items 23a or Examiner must be I Funeral 20852 1799 EAST JEFFERSON STREET,#116 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. ian "natural", or Medical Examin þ 1 Never Married 2 Married Maryland 21215-0036 WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) n and Mental Hygiene.

7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) **PUBLISHING** FINANCE ANALYST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ BRENNER SARAH HERSHKOWITZ SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 22898 N. BROWN SQUARE , ASHBURN, VA CAROL FLICKER/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place, TOMS RIVER, NJ 4 ☐ Donation 5 ☐ Other (Specify) MEM. PK. 06/27/2011 B'NAI 22. Name and Address of Facility SOL LEVINSON 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Mast Leuins 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_{sician}/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, If any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami -transit and resulting in death) Last burialattending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctonic pregnancy in the past 12 months?

1 Yes 2 Yo

9 Unknown signed by the atte Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N vorus Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate completed filled in hours. 1 Yes 2 No eral Director: After this certificate filled in by the funeral director, pag 25. Was case referred to medical 26. Place of Death (Check only one) To Be Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\text{Other}(Specify) \) YVING 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1. Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) MD D69568

Registrar
DHMH 17 Rev 7/2009

State

1801 E Jeffersonst Rockville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

· Chilakamarri

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June tergusor 201 6:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Home If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 Hours (Month, Day, Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Eldone 21229 USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 0 Black, White, etc. þ 1 Neyer Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) sabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Balto. MD permit. Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Arbufus 1 4 Donation 5 Other (Specify) 21. Signature of For eral Service Li + nsee Balto MD 23a. Part 1 Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or eart failure. List only one cause on each line. Approximate Interval Between Immediate (use (Final disease or o ndition resulting in death) Sepsis Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day 1 Yes 2 9 Unknown 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by failure renal 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should cardiac arrhythmia, 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No 2ndo earditis 24a. Was an autopsy SIP mital valve replacement with bioprosthetic certificate | 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: မ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0053928 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURAIYA BEGUM, MD 2434 W. BELVEDERE AVENUE, BALTIMORE, MD - 2 31. Date filed (Month, Day, Year) State JUN 2 8 2011

DHMH 17 Rev 7/2009

Registrar

11-04686 Kathryn Grubby

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day June 23, 2011 **Medical Examiner** Kathryn Randall Grubby 0152 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hanover Pike and 5th Avenue **Baltimore County** 5 Social Security Number **Funeral** 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Davs Hours Min. 219-23-0090 22 Country)Maryland 1 M 2X F 27,1989 Mar Usual Residence of Decedent E G 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Maryland Baltimore Reisterstown Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nent. If item 27 is marked other than "matural", or items 23a or 23a-f sho rother traumatic event; the Medical Examiner must be nofified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Aldyth Avenue 21136 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. 1 Yes 2X No 3 Widowed 4 Divorced f Yes, Give Year Specify: White 1 Yes 2 X No specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 12 Student Cosmetology 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Timothy Grubby Robin Hannan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 417 Bethlehem, NH 03574 Robin H. Grubby, Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department c 06/24/11 Baltimore, Maryland Donation 5 Other Specify: Metro Crematory Inc. 5 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Momow 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on e een Onset and /Medical a Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed the attending physician and led for use as the burial - tran Physician/Medical UNPENDED AMENDED Box 68760, IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death Day past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 V No 9 Unknown g Unknown of Vital Records, P.O. certificate has been signed by rector, page 2 should be detache Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed?

Yes 2 ✓ No death? Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other₄ Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes 2 No 28a. Date of Injury (Month Day Year) Jun 23, 2011 After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject was passenger of a car that lost control 1 Natural Division 0000 hrs neral Director: A 5 Pending 1 Yes 2 V No and hit a tree 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) Hanover Pike and 5th Avenue , Hanover , MD within 24 hours at To the Funeral D determined (Specify) Local Street 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 W Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and title of eq 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 23, 2011 delle 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month Day) 32. Registrar's Signature Registrar

State Registrar

FI :-

Baltimore, Maryland 21215-0036

Box 68760

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Records,

of Vital

Division

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M.D.

Registrar's Sign

CUNNINGHAM

Month, Day, Year)

TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Emily Gilroy Month 2:050 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death COASita Salisbury Wicomico HOSDICE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-50-4516 1 M 2 XF Months Davs Hours Min. (Month, Day, Year) 63 Director 01/13/1948 Usual Residence of Decedent show or 28a-f show 10b. County 10a, State death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD Somerset Princess Anne TyL Yes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Funeral 30532 Creekview Drive 21853 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces Black, White, etc. þ be filed within 72 hours after of 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 ☐xNo Specify: If Yes, Give White 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) event, the Bartender Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental marked ဂ္ Charles DeBow permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Margaret Core 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gilroy John Spouse 30532 Creekview Dr., Princess Anne, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date remetery, crematory or other place)
Final Jounrey Crem. 1 Burial 2 remation 3 Removal from State 6/29/2011 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services
PO Box 1413, Baltimore, MD

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 1203 Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ASLVD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Pregnant at time of death 9 Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death?

1 Yes 2 No Yes & No this certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: Coonscar No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of HOSpiel at Certificate: 28c. Injury at 28d. Describe how injury occurred s after dea. iniury work? Natural 5 Pending 2 No Investigation Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) C 63199 25 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 EASTERN SALISBUKY 21804 86. DIZ HO VOHER SHOFE 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Physician /Medical **Examiner** certificate be executed Exam

Physician

/Medical

Examiner

Director

by Funeral

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Pages 1 and 2 should be filed within 72 hours after

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permit. Pages 1
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Important: If ite
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and burial-trai attending physician as the use ō the has certificate this

Physician/Medical

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Completed

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Certification:

Medical

29b. Signature and title of certifier

P.O. Box 68760,

Division or Vital Records,

To the Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director: After of the funeral piled in by the funeral completely filled in by the funeral funera

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Every long to the cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No performe 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 1 🗌 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIM FARSHALL, 9105 (FRA)

and manner stated.

FRANKHN SQUARE DR.

29c. License number

ORIGINAL

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20495 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1606 Johnnie Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Saint Agnes Hospital Baltimore ocial Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign 1 M 2 □ F Months (05 Yrs. Month, Day Director Usual Residence of Decedent show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director timore 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral Gelston 21229 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
1f Yes, Give 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: Black Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) sablea Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ K. Johnnie Jaomi ames 19a. Informant's Name/Relationship (Type, Print) Angela Goddard U 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gelston DR. Balto. MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State rownsville 4 ☐ Donation 5 ☐ Other (Specify) insville, mo Juneral Service Licens 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Move May 20 pers Immediate Cause (Final Athenschentie Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death). Examine Due to (of as a consequence of). or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) resulting in death) Last inding physician use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ رحد ماطيه 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 2 No Yes 1 Yes Division of Vital director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examinet? 2 🗆 No Other: Medical Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this the funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be within 24 hours after deal To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D0068107 June 21 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Villarreal Alejandro 900 South Caton Avenue Baltimore, MD 21229

DHMH 17 Rev 7/2009

State Registrar

Johnn

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year <u>и</u>иэ. Medical 201 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death BURN Himoge Washington Glen Medical Center Unne Funeral Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 🛛 M 2 🗆 F Months Days Hours Min 219-32-3219 Director 74 Pennsylvania October 31, 1936 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Glen Burnie 1 Yes 2 K No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event the Madison Form. Funeral 7605 Stoney View Drive 21060 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Completed 3 Divorced 4 Divorced Specify: Year or Dates White 1962 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Continental Baking Co. Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Simmons Glenn Himes Ethel Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Himes (Wife) 7605 Stoney View Drive, Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 K Cremation 3 Removal from State cemetery, crematory or other place June 25, 2011 Atlantic Crematory, LLC Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Maryland 21122 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) AMERICANOMIUS DIUSSOIDSAD 2440 Ol Medical Due to (or as a consequence of) **Examiner** CHRONIC KIDNEY 104EARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PERIPHERAL UASCULAR DISEASE 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performe death? After this certificate 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No ျ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 K Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending iniury Accident Investigation 1 Yes 2 No 3
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Example 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier an congrad axunalisto D008511A コヘカモ ブン・ブロリノ

- loyl

State Registrar 301 HOSPITAL DRIVE, GLEN BURNIE, MD 20161

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIANGRECO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma		partment of Hertificate of D	ealth and Mental eath	Hygiene	20497	
	Physicia		1. Decedent's Name (First, Middle, La Dorothy F.	/				of Death	3. Time of Death	
, AC.,	Medic Examir		4a. Facility Name (if not institution, giv Stella Maris F	lospice		4b. City, Town, or L	ocation of Death	4c. County of D	4c. County of Death Baltimore	
	Funeral Director			Sex 7. Age	(In yrs. last birthda 91 Yrs	Months Davs	Hours Min. 8. Date (Mont		Birthplace (State or Foreign Country) Maryland	
	//aryland 8a-f show tified at	rector	10a. State 10b. County 10b Balti		10c. City, Town or Glen				10d. Inside City Limits 1 ☐ Yes 2 🛣No	
	with the N s 23a or 2 rust be no	Funeral Director	10e. Street and Number 11505 Manor Ro	ad		10f. Zip Code 2105	7	10g. Citizen of What United	Country? states	
0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates.	lo	1 🗌 Yes 2 💢 No		r No- .) 14. Race - A Black, W Specify: N		
JUNE 28, 3:45 a.m. Baltimore, Maryland 21215-0036	within 72 ho giene. er than "na the Medic	Completed	15. Decedent's I (Specify only highest g.		(Gi	cedent's Usual Occupat ve kind of work done du DO NOT use retired) DUSEWife	ion ring most of working	16b. Kind of Busine At Hom	,	
:45 a	2 should be filed ith and Mental Hyg 27 is marked oth traumatic event.	To Be	17. Father's Name (First, Middle, Last) Charles Precht				18. Mother's Name (First, Mi Susan Pre			
28, 3 e, Mar	and 2 shou Health and em 27 is m ther traum		19a. Informant's Name/Relationship (Eugene Menin-		19b. Ma 11:	ailing Address (Street an 505 Manor	Road, Gler	umber, City or Town, State, 1 Arm, MD 21	Zip Code) 057	
JUNE ?	t. Page 1 a tment of H tant: If ite ijury or oti		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec		Holy R Cemete	position (Name of rematory or other place) edeemer ry	June 30 2011	Baltimo	ce, MD	
Bal	permit. Departn Imports any inju		21. Signature of Funeral Service Licen	ala	wo	22. Name and Address Evans Fun 8800 Harf	eral Chape ord Rd. Par	l & Cremation rkville, MD	n Services 21234	
	Physician/		25a. Part 1. Enter the disease, or complete the process of heart failure. List only disease or condition	plications that caused to be cause on each line.		nter the mode of dying,	such as cardiac or respirate	ory arrest,	Approximate Interval Between Onset and Death	
	Medical Examiner		resulting in death) Sequentially list conditions,	b. —	consequence of):					
17%	ecuted and Il-transit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or iirijury that initiated events resulting in death) Last	C	consequence of):					
092	cate be ex physician s the buria	edical	L	d						
HANLEY P.O. Box 687	sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at t 9 Unknown	Fetal death	Ectopic pregnancy Other (specify)		23d. Date of Month	delivery Day Year	
~	quires that t en signed b uld be deta	by	Part II. Other significant conditions of	ontributing to death but	t not resulting in th	e underlying cause give		Did tobacco use contribute	to the cause of death? Probably 4 □ Unknown	
DOROTHY Records,	The law recate has be page 2 sho	Completed						autopsy prior t performed? peath	autopsy findings available o completion of cause of ? Yes 2 \(\sum \) No	
Vital	hysician: nis certific I director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No	Hospital:	it 2 🗆 ER/Outpat	Other:	e of Death (Check only one) 4 Nursing Home 5	Residence 6 🕱 Other (Sp	ecify) HOSPICE	
Division of Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not be	ribe how injury occurred						
Divis	To the Hospital or Attent within 24 hours after deat To the Funeral Director. completed filled in by the		4 Homicide determined	28e. Place of Injury building, etc.	(Specify)	street, factory, office	City o	ion (Street and Number or I r Town, State)		
	thin 24 ho thin 24 ho the Fune impleted f	Medical	(Check 2 Medical Exam	iner: On the basis of exa	mination and/or inv	estigation, in my opinion, e, death occurred at the t	ime, date and place, and due	tate and place, and due to the to the cause(s) and manner	e cause(s) and manner stated. as stated.	
	\ \		> 47AA	esca N	P	29c. License n	9792	29d. Date signed (No.	O	
	٠١		30. Name and address of person who JACKIE JONES, CR	NP, 2300 DI	JLANEY VA	LLEY RD.	rimonium, md	21093		
	Stat Registra	e ir	JUN 2 8 2011	32. Registrar	Signatur					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 28, 2011 2:30 P M HARRINGTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HARFORD FOREST HILL HEALTH & REHAB CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Hours Feb. 4, Yell 916 212-26-6830 1 □ M 2700F 95 Virginia **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f showany injuy or other traumatic event, the Medical Examples. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Maryland Bel Air Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21015 2156 Thomas Run Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Yes 2XNo If Yes, Give Year or Dates. 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: 3 XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elizabeth Blankenbeckler Frank Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2154 Thomas Run Road Bel Air, Maryland 21015 Thomas Harrington, Sr. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 29, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Evans*Funeralochapel Bel Air Forest Hill, Maryland 2011 of Funeral Service Licensee Signatur 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ 5 Tax disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the burial-transit Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 Yes 2 been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed has 2 No Ves 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D32299 JUNE 27 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEL AIR MD, 21014 615 W. MACPHAIL ROAD DAVID DUNN State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Hustings Physician/ 20 P M Gloria 27 Tune 7011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Randallstown Seasons Hospice @ Northwest Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F June^{th,} 30, 1940 216-36-1205 70 Maryland Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director r 28a-f st notified 1 Yes 2 No Baltimore Reisterstown Maryland 10e. Street and Number 10g. Citizen of What Country? ö items 23a or ner must be r Funeral 21136 409 Nettle Hill Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Force Black, White, etc. ö þ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates. 3 Widowed 4 X Divorced "natural" Completed 1 and 2 should be filed within 72 hours of Health and Mental Hygiene.
item 27 is marked other than "natu other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Car Dealership 10 Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ida Gregory Roscoe Plaine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 409 Nettle Hill Lane Reisterstown, Maryland 21136 Denise Hastings, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ö permit. Page Department or Important: If any injury or 06/28/11 Baltimore, Maryland Metro Crematory Inc. Signature of Funeral Service Licensee Thomas Gregor ^{22. Name and Address of Facility} Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, neach line. Immediate Cause (Final Onset and Death cuncer Lund Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): signed by the attending physician and deetached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time - 1 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed this certificate has been si ral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 124 hours after death.
 Funeral Director: After this certificate has be as the control of autopsy performed? Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one, 4 Nursing Home 5 Residence 6 Other (Specify) examiner' Other: 2 17 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 5 Pending Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funel completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) nský upaknem.D D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 5-203 21209 NS-RajapakseMD 2835 Smin 31. Date filed (Month, Pay, Year) 32 egistra Sign Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Maranda Michelle Hunter 11:05A June Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1534 Oakridge Road 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours Min. Director MARV Usual Residence of Deceder show ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1X Yes 2 ☐ No MD 10e. Street and Number 10g. Citizen of What Country? Funeral OAKRIDGE U.S.A items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married ō þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: BLACK "natural". Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Hygiene. NONE life. DO NOT use retired) UNEMPLOYED Elementary/Seconday (0-12) should be filed with and Mental Hygien is marked other tl injury or other traumatic event, Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 2/2/8 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s if Health item 27 i MOTHER NENDYM. 1534 TIMORE, MARYIAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 27/2011 BALTIMORE, MARYIAND 4 Donation 5 Other (Specify) DERRICK C. JONES FIHIPA 21. Signature of Funeral Service Licenses 22. Name and Address of Family 7 md. AVE. BALT, MURE 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final ondros arcon Meserchymal Physician/ Vea disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examin sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): nding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 1 \(\text{Nesidence} \) 6 \(\text{Other} \) Other (Specify) ျပ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 X Natural 5 Pending Accider Suicide 1 Yes 2 No Accident Investigation completed filled in by the within 24 hours after deal To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗍 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and the of certific 29c. License number 29d. Date signed (Month, Day, Year) D527 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

600 N Worke

Hopkins

Johns

MD, PLD

31. Date filed (Month, Day,)